NOT FOR PUBLICATION JCVI(93)

JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

MINUTES OF THE MEETING HELD ON 7 MAY 1993

Agenda Item Number 2.

JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minutes of the Meeting held on Friday 7 May 1993,
in The London Park Hotel, 10.30am.

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 P Grob
Dr I Jones
Professor H P Lambert
Professor R J Levinsky
Dr J A MacFarlane
Professor C S Peckham
Mrs D Roden
Dr S G Schild
Dr J B Selkon
Dr D Walford

SECRETARIAT:

Dr D M Salisbury, HP(M)1
Mr L T Wilson, HP(A)3B

INVITED TO ATTEND:

Dr N T Begg, CDSC
Dr E Miller
Dr T V O'Dwyer, Ministry of Health (Republic of Ireland)
Dr J Pillaye, HEA
Sir Joseph Smith
Dr S Tamblyn, Ministry of Health (Canada)

OGD REPRESENTATIVES, etc.:

Dr J Faithfull Davies MoD
Mr L Findlay, SOHHD
Dr A Greer, DHSS (NI)
Dr J Ludlow, Welsh Office
Dr O A Thores, SOHHD

DEPARTMENT OF HEALTH:

Ms H Campbell, HP(M)1
Mr F Coleman, HP(M)1
Mr R M Freeman, HP(A)3B
Dr J Leese, HP(M)1
Mr P Hayes, HP(A)3B
Mrs S Philogene, NUR
Miss J StJuste, HP(A)3B

1) ANNOUNCEMENTS

The Chairman welcomed Dr Diana Walford, newly appointed Director of the Public Health Laboratory Service, and Dr J Pillaye from the HEA, to their first JCVI meeting.

Apologies for absence were received from Professor A M Geddes, Professor D L Miller and Drs D Reid and C Bartlett.

2) MINUTES OF THE MEETING OF 6 NOVEMBER 1992

These were read and agreed as a true record.

3) MATTERS ARISING

There were none.

4) UPTAKE REPORTS

4.1 COVER REPORT AND IMMUNISATION STATISTICS **JCVI(93)1**
Report by Dr Norman Begg and Dr David Salisbury

National coverage remained high - over 90% - for all antigens with DT Polio at 95%. Data for the new Hib vaccine had also been received for South East Thames RHA and Wales with uptake in the first cohorts immunised under the routine programme showing coverage only slightly lower than for DTP, a remarkably high uptake with virtually no refusals. 95% of districts in England, Wales and Northern Ireland provided COVER figures.

4.2 IMMUNISATION COVERAGE: NORTHERN IRELAND **JCVI(93)2**
Report by Dr Angela Greer

Good uptake was reported for all Boards although the Eastern Board (Belfast) did lag behind a little. No Hib figures were yet available. There had been a brief problem with MMR vaccine supply.

4.3 IMMUNISATION COVERAGE: WALES **JCVI(93)3**
Report by Dr Jane Ludlow

The improving trend in immunisation uptake was continuing although pertussis vaccine uptake did lag behind.

4.4 IMMUNISATION COVERAGE: SCOTLAND
Report by Dr Alastair Thores

Scotland's uptake figures were tabled. In Scotland overall figures were good; Hib figures were not yet available. There were problems with the community health index which prevented Scotland providing COVER-style figures and it was not possible to say how comparable Scotland's statistics were with COVER. The figures were, however, challenged as being possibly inaccurate. Recall figures were available for most of Scotland and these could provide COVER-like data. The denominator was one problem which

was being addressed and it was also suggested that the assisted practices scheme resulted in the poor immunisation uptake figures in the Western Isles. The Chairman requested evidence of the cause of Scotland's problems so that the possibility of Scotland providing figures comparable to COVER could be investigated.

The Republic of Ireland's figures were not encouraging although the introduction of the Hib vaccine had helped with the uptake of other vaccines. The whooping cough High Court case had led to negative propaganda and had resulted in DT vaccine, rather than DTP, being given in many cases. It was suggested that similar cases could come to light in the UK.

5) **IMMUNISATION CO-ORDINATORS MEETING** **JCVI(93)4**
Report by Mr Len Wilson

An additional paper on this was tabled. The meeting had been very successful with the turnout, programme and discussion being encouraging. The explanation given of the vaccine supply situation had been very helpful.

6) **MMR VACCINE**

6.1 **MMR SUPPLIES** **JCVI(93)5**
Report by Mr F Coleman

A brief history of the present supply situation with regard to MMR vaccine was given.

MSD had, prior to September 1992, provided only 20% of the UK's requirements; this had had to increase to 100%. Despite the greatly increased quantities of vaccine secured by the Department of Health the need to refill the 'pipeline', aggravated by disproportionate ordering by some districts, had resulted in shortages. These problems had been resolved when the Department took central control of distribution. A further problem had arisen when the US manufacturers changed their packaging firm in Europe. Following that hiatus in supply large stocks were due and normal arrangements would apply from July 1993; any existing shortfalls would be made good. The analysis of the returned discontinued vaccines had provided some worrying information that doctors were holding stocks of time-expired vaccine.

The Health Departments had had a difficult time with regard to MMR supply, problems caused in the main by the manufacturers. Other vaccine manufacturers producing MMR which contained the Jeryl Lynn strain of the mumps virus included RIVM (under a very prescriptive licence from MSD making sale in the UK impossible) and Rubini in Switzerland (a vaccine which lacked sufficient study in the field to be certain that there would not be a Urabe-like problem). Merck and Merieux were collaborating to produce a Jeryl Lynn strain vaccine whilst SKB continued to sell the Urabe strain vaccine without liability. Merieux's Urabe strain vaccine was still in use in Sao Paulo in Brazil where independent studies had given similar results to the UK studies confirming the wisdom of the UK's discontinuation of the two Urabe strain

vaccines.

6.2 MMR VACCINE SUPPLIES JCVI(93)6
Letters to Immunisation Co-ordinators

These were noted.

6.3 MEASLES/ RUBELLA STRATEGY MEETING JCVI(93)7

(a) Report of meeting: Dr David Salisbury

(b) Measles and Rubella Epidemiology in England and Wales: Dr Elizabeth Miller.

This meeting had been held on 16 March under the chairmanship of Sir Joseph Smith. Its purpose had been to examine the present position for measles and rubella immunisation in the UK, to consider strategies for the future and to discuss the operational strengths and weaknesses of the different possibilities. In attendance were experts from the field, representatives from CDSC, CPHL, NIBSC and the four UK health departments and Dr Ciro de Quadros from the Pan American Health Organisation. The meeting considered, amongst other matters, the current epidemiology of measles and rubella in England and Wales, mathematical modelling for measles and rubella strategies, measles surveillance and elimination strategies in the Americas and operational issues for measles strategies.

The strategy meeting had concluded that, despite the very successful measles and rubella immunisation programmes in the UK, and even with the use of the two dose strategies adopted by other countries, elimination of measles would not occur. Small outbreaks were being seen in school age individuals for measles, and colleges and universities for rubella. The susceptibility to measles of the 7 to 9 age group was increasing. Immunisation campaigns such as those conducted in Central and South America had had impressive results and the strategy meeting had recommended that further consideration be given to the practicalities and costs involved in mounting such campaigns. Other points noted at the strategy meeting were the inaccuracy of clinical diagnosis in young children (only 10% showed serological confirmation) and the great value of the saliva tests being developed by PHLS.

The Committee agreed that it would take a long time to reduce the number of rubella susceptible males and that the introduction of Measles/Rubella vaccine for girls and boys at age 10 to 13 might be an easy but short term solution. Interrupting transmission was the answer but it was agreed that we were not yet at that stage. The need to educate the media was noted.

It was agreed to accept the strategy meeting's recommendations and it was requested that they be further developed for the next JCVI meeting.

(c) **Results of natural and vaccine exposure on maternal measles antibody transmission: Dr Norman Begg.**
(d) **Implications of Saliva and Antibody testing for Surveillance: Dr David Brown.**
(e) **Mathematical modelling of measles and rubella strategies: Dr James Nokes.**
(f) **Measles surveillance and elimination strategies in the Americas: Dr Ciro de Quadros.**
(g) **Operational issues for measles elimination: Dr David Salisbury.**

These articles were noted.

6.4 MMR ARTICLES FOR INFORMATION **JCVI(93)7a**

These articles were noted.

Attention was drawn to Dr Miller's co-authored article in The Lancet. There had been no laboratory confirmed cases of aseptic meningitis since the introduction of MMR. Since September 1992 only two 'yellow card' reports showed any hint of problems caused by the Jeryl Lynn strain of the MMR vaccine - one meningococcal meningitis and one meningitis without hospital admission. Cases would be quickly picked up.

7) Hib VACCINE

7.1 Hib Vaccine Supplies **JCVI(93)8**
Report by Mr F Coleman.

There had been some initial supply problems with the Hib vaccine which had arisen from the need to provide all the stocks GPs wanted. However, any problems were quickly resolved and there were no shortages now. 100,000 doses of the Lederle vaccine were in stock; when they were exhausted, only Merieux would be available. The dangers of having a single supplier, alternative options to such a development and the possible future development of DTPHib quadrivalent vaccines needed full consideration.

There had been no reports of any reactions when the two different brands of vaccine had been changed mid-course. Studies of the interchangebility of vaccines were needed but it was acknowledged that a monopoly supplier would obviate the urgency of a need for such a study. It was felt that such studies should be conducted by a body other than the manufacturers. Whilst a study covering all the permutations would take some time to do, a smaller one could be done in only a few months. It was felt that there might be difficulties getting such studies accepted by local ethical committees as it was possible that those children in the trial could be put at a disadvantage compared to children routinely immunised. Animal studies could be done quite quickly and would be helpful. Parents had showed little interest in studies for a quadrivalent vaccine and recruitment for the current study of Merieux and Lederle mixed with Evans DTP was slow as there is good acceptance of separate Hib and DTP injections.

The new contract for vaccine supply would run from October 1993 to April 1995. During this time quadravalent vaccines were likely to become available. These would be immediately demanded by people in the field, although the 12 months shelf-life of vaccine in the GP's surgeries should slow this demand down. Contracts with manufacturers include a let-out clause should another manufacturer produce a successful quadrivalent vaccine during the period covered by the contract.

It was agreed that the hands of the Department should not be tied during such delicate negotiations; nevertheless, when possible, supplies from more than one manufacturer was preferable. It was agreed not to go ahead with any studies of the interchangeability of the vaccines at present.

7.2 **Hib ADVERSE REACTIONS** JCVI(93)9
Report by Dr David Salisbury

JCVI(93)9, which summarised the first 800 yellow card returns on the Hib vaccines, had been seen by the Committee on the Safety of Medicines. The results had to be interpreted with caution. No new reactions were reported that were not seen with any of the other vaccines given at the same time, or that were different from events seen at those times in the absence of immunisation. The Committee was reassured by the data.

7.3 **Hib SURVEILLANCE** JCVI(93)10
(a) Report by Dr Norman Begg

The BPSU was investigating reports of Hib in immunised children. There had been only four genuine vaccine failures, 3 in the 'single dose' children over 12 months and 1 in the three dose regime (Merieux). This represented 4 cases in 3.5 million doses, an extremely low level of vaccine failure. There may be some underreporting but, to address that possibility, all reports of Hib to PHLS were being investigated and vaccine histories checked. A striking decrease in disease had already been seen.

(b) Report by Health Education Authority

Dr Pillaye presented the paper in the absence of Mr Corr. The HEA research showed a high awareness of the new vaccine, especially amongst mothers of those children in the main target groups. The lack of impact upon parents' confidence in vaccines following the discontinuation of the two brands of MMR vaccine was also noted.

Dr Pillaye also reported that the HEA was conducting four other relevant studies:

1) a study of the reasons for refusal of the Hib vaccine;
2) a study of attitudes to immunisation amongst GPs;
3) a study of 500 parents who accepted immunisations and 500 who refused and an assessment of their characteristics and reasonings;
4) a study of single-handed GPs and mobile populations.

The results of these studies would be known by the end of the summer.

7.4 **PRESS RELEASE**
Success of Hib Immunisation Programme JCVI(93)11

This was noted.

7.5 **Hib ARTICLES FOR INFORMATION** JCVI(93)12

These were noted.

8) **DIPHTHERIA**

8.1 **Paper on Diphtheria: Future Strategies**
Report by Dr David Salisbury JCVI(93)13

8.2 **Diphtheria Sero-Epidemiology**
Report by Dr Elizabeth Miller JCVI(93)14

8.3 **Diphtheria in Europe** JCVI993)15

Although there was no diphtheria in the UK its re-occurrence was a possibility bearing in mind recent developments in Europe. A diphtheria epidemic in Moscow and St Petersburg had spread throughout Russia and into northern Norway and Finland. In the UK, utilising the population-based MMR surveillance, the PHLS had checked the level of diphtheria antibodies and these had shown that a significant proportion of older people were possibly susceptible to the disease. With increased population movements in Europe there was a greater risk of importing the disease into the UK. The Committee was asked to consider whether these points gave cause for concern and what action, if any, was now required. There was also some concern about the level of protection against tetanus in the UK population.

It was pointed out that some of the data presented to the Committee was not in a form in which it might be best presented as the data showed antibody data measured by ELISA rather than using a direct test of immunity; ELISA antibody levels did not necessarily indicate levels of protection. It was felt that levels of susceptibility may be even worse than the figures suggested. As the first cases in the epidemic had been in immunised adults it might suggest that vaccine induced immunity does not persist, although the vaccines used in the former USSR might not be comparable with those used in the UK.

The non-availablity of a suitable diphtheria vaccine gave immediate concern. No costings had yet been done on two possible options for dealing with the matter: replacing the school leaving tetanus booster with Td vaccine (about 1m doses per year) or replacing all tetanus immunisations with Td (about 6/7m doses per year). Advice on immunisation for travellers had been given in the CDR although it was acknowledged that more might be needed on this front.

It was agreed to seek further information on all these matters, including looking into all aspects of changing the school programme, and to consider the issue of a CMO letter as an interim step. The Committee recommended that, in the light of the antibody data, and subject to confirmation with an assay that showed protection, the school leaving tetanus booster should be changed to Td. Consideration would be given to replacing all T with Td if the serology confirmed the susceptibility of older groups.

8.4 **CDR Diphtheria Issue** JCVI(93)16
8.5 **Diphtheria articles for information** JCVI(93)17

These articles were noted.

9) **SINGLE ANTIGEN PERTUSSIS VACCINE** JCVI(93)18
Report by Dr David Salisbury

This vaccine was used for parents who, having rejected DTP vaccine, later wanted to have their child immunised against pertussis. Between 20,000 and 80,000 doses had been used each year but, from August 1992, the vaccine had no longer been manufactured; no other manufacturers had shown any interest in developing the vaccine. Acellular vaccine was available from CAMR; this had shown good immunogenicity and CAMR were prepared to release it as an unlicensed product. In the long term manufacturers could be asked to produce a single antigen vaccine without the Department specifying whether whole cell or acellular vaccine should be produced but the short term situation, with the cyclic upsurge in pertussis due in 1994, required urgent consideration.

Concern was expressed that the CAMR vaccine had responded poorly in studies in the USA. It was also felt that, with the JCVI's record of meticulous responses and recommendations, it would not be right for the Committee to set such a precedent as to recommend an unlicensed vaccine using Crown Immunity as a defence against adverse events. Pertussis vaccine was also still a matter of concern to some parents.

It was agreed not to recommend use of any alternative single antigen vaccine but to use this development as a good opportunity to remind parents of the importance of, and the availability, of the triple vaccine. Further efforts would be made to obtain licensed vaccine, ideally from Evans.

10) **HEPATITIS A AND HAEMOPHILIACS** JCVI(93)19
Report by Dr Judith Hilton

Dr Leese spoke on this paper in Dr Hilton's absence. This item had yet to be fully discussed by the Advisory Group on Hepatitis and the conclusions, on which reservations were expressed, were only options. In Ireland, where the recent problems appear to have originated, hepatitis A vaccine was being offered to all haemophiliacs; there were some litigation threats. It was felt

that the problem may resolve itself and it was agreed that immunising haemophiliacs was desirable.

11) HEPATITIS B AND HEALTH CARE WORKERS RECOMMENDATIONS OF THE ADVISORY GROUP ON HEPATITIS **JCVI(93)20**

The issue of the document on HIV infected Health Care Workers had delayed the issue of the Hepatitis B document. The booklet had been printed but the implementation guidelines were not yet ready. Questions were also asked about the price being paid for the vaccine in the UK; it was agreed that the Department would again talk to the NHS Supplies Authority about this matter.

12) JAPANESE B ENCEPHALITIS ADR STUDY **JCVI993)21**
Report by Dr Norman Begg and Dr Jane Leese

This small study had suggested that the vaccine had not been a major cause of adverse reactions in the UK. The Biken vaccine was now licensed in the USA and available to GPs in the UK.

13) INFLUENZA PANDEMIC PLAN **JCVI(93)22**
Report by Dr Jane Leese

This paper was to be considered at the next meeting of the Committee's Influenza Sub-Group. The likely attack rate if it had been possible to run an immunisation campaign was queried.

14) MENINGOCOCCAL INFECTION IN LABORATORY WORKERS **JCVI(93)23**
Report by David Salisbury

The Committee's views were sought on the immunisation of laboratory workers exposed to meningococcal infection. It was agreed that the main problem lay in laboratory practice involving heavy suspensions of N. meningitis. Immunisation was needed only for specialised laboratory workers but good laboratory practice was essential.

15) CHILDREN'S VACCINE INITIATIVE **JCVI(93)24**
Report of the Task Force on Priority Setting and Strategic Plans.

This was provided primarily for information but it did provide a useful cost benefit analysis and a priority list for vaccine development.

16) ARTICLES FOR INFORMATION **JCVI(93)25**

17) ANY OTHER BUSINESS

i) BCG SUB-COMMITTEE MEETING MINUTES

Notifications of TB were increasing although it was not yet

possible to pinpoint in which groups of the community this was especially occurring. The PHLS Survey was underway and the inclusion of anonymous HIV testing was an important new component. The results of the 1988 Survey had been published in 1992. The schools immunisation programme was continuing although 15 districts had ceased routine immunisation.

ii) LETTER FROM OLDHAM HEALTH AUTHORITY

It was agreed that school leavers should receive the tetanus vaccine boost irrespective of any vaccine they may have received in A&E Units.

iii) RABIES

It was suggested that the new 3 dose regime could dissuade people from being immunised and that the third dose was probably only essential for those in high risk occupations. Dr Leese was asked to review the data on which this recommendation was made.

iv) PNEUMOCOCCAL VACCINE

This vaccine had been quickly exhausted following issue of "Immunisation against Infectious Disease"; new batches were due from 19 May onwards.

v) BCG IMMUNISATION OF PATIENTS WITH SCARS BUT NEGATIVE HEAF TEST RESULTS

It was agreed that this should be considered by the BCG Sub-Committee.

vi) REFUGEES

It was agreed that refugee children (eg. those from Yugoslavia) with uncertain immunisation histories should start a completely new course of immunisation.

18) FUTURE MEETINGS

5 November 1993 was confirmed.