

CDC: High-Risk Patients Got Flu Shots This Year

BY ALICIA AULT
Contributing Writer

WASHINGTON — Despite the severe shortage of influenza vaccine this winter, the elderly, young children, and others at risk were able to find and receive shots, officials said at the National Immunization Conference sponsored by the Centers for Disease Control and Prevention.

Once it was known last October that Chiron Corp. would not be able to deliver its half of the nation's vaccine supply, the CDC immediately set up a special surveillance team to track where the vaccine was going and who received it, said Susan Chu, Ph.D., acting director of the agency's Office of Science Policy and Technology Transfer.

Seventeen new questions on the flu vaccine were added to the monthly Behavioral Risk Factor Surveillance System survey. From November 2004 to February 2005, 105,473 adults, and 35,106 children (by proxy) were interviewed, said Michael Link, Ph.D., of the CDC's behavioral survey branch.

And, in a change of pace designed to

keep state and federal agencies on top of the shortage, data were submitted to CDC weekly, not monthly, and were analyzed within days, giving states new data every 12 days or so, Dr. Link said.

As of late March, the survey found that vaccines were received by 63.5% of respondents over age 65 years, 26% of 18- to 64-year-olds at high risk, and 36% of health care workers, said Gary Euler, Dr.P.H., of the CDC National Immunization Program's epidemiology and surveillance division.

These figures were slightly higher than those gathered through January and reported in the CDC's Morbidity and Mortality Weekly Report. According to those data, 62.7% of those over aged 65 years, 25.5% of those with high-risk conditions aged 18-64 years, and 35.7% of health care workers received vaccinations (MMWR 2005;54:304-7).

Through February, among healthy

Americans, 7.2% of those aged 18-49 years, and 17.3% of those 50-64 years said they had been vaccinated, compared with 6.9% and 16.5%, respectively, through January.

Of children aged 6-23 months, 52% received a vaccine (up from 48.4% through January), which was a high uptake rate, given that 2004 was the first year the CDC's Advisory Committee on Immunization Practices recommended adding the flu shot to routine immunizations, said Carolyn Bridges, M.D., an epidemiologist with the agency's influenza branch.

Dr. Euler said there was room for improvement, as the survey found that many parents said they did not get vaccines for their children because they did not think their children needed them.

The demand for vaccine among patients aged 65 years and older was mostly met, though there was some problem

getting vaccine in early November, Dr. Euler said.

An audience member questioned whether some of the demand had been met in Canada. As part of the survey, patients were asked where they got a vaccine. So if they went to Canada, those data would be captured, though they have not been analyzed yet, Dr. Euler said.

Vaccination rates also varied from state to state. Preliminary data indicate that states with lower immunization coverage had a smaller vaccine supply. Further analysis of the variation and the entire flu database will be coming over the next 6 months, Dr. Link said.

The CDC researchers acknowledged that the survey was limited because it is self-reported information, and does not cover people who are institutionalized.

Dr. Bridges said the CDC currently is researching whether faster analysis of flu data helped states with their shot distribution and management. And, she said, since it was an expensive undertaking, it's not clear if it will be repeated next year, or only in times of pandemic or shortages. ■

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Hepatitis A Vaccination Urged for Children Older Than 2 Years

BY LINDA LITTLE
Contributing Writer

SCOTTSDALE, ARIZ. — Vaccination for hepatitis A should be extended to children above the age of 2 with catch-up immunization for older children and adolescents, William F. Balistreri, M.D., advised.

"We need to rethink the vaccine strategy to see if we can have a rational plan for hepatitis A that would be more inclusive," said Dr. Balistreri, director of pediatric gastroenterology, hepatology, and nutrition at Children's Medical Center, Cincinnati.

He advised physicians to vaccinate children over the age of 2 years.

Physicians "need to get beyond these barriers and vaccinate these children. We have a vaccine that works. We have a disease that can kill," Dr. Balistreri said in an interview.

Major outbreaks of hepatitis A still occur in the United States; the majority of these are food borne, he said at a pediatric update sponsored by the Phoenix Children's Hospital.

Children play a vital role in the spread of hepatitis A virus, which can be transmitted through food, fecal matter, and person-to-person contact.

"Day care is a hotbed for transmission," he said. "You have lots of children, few caretakers, everything goes in the mouth, caretakers may change the diaper on the same surface where children play, and children excrete the virus longer [than adults]."

To make matters worse, a young child can be infected and have few, if any, symptoms. Usually, outbreaks in day-care centers are detected only after the adult contacts become sick, he said.

While 85% of adults will become jaundiced, only about 10%-15% of children do. Children are likely to have a mild fever, a

runny nose, and maybe a little diarrhea, Dr. Balistreri said. "Some children have no symptoms whatsoever."

In contrast, adults become jaundiced and have nausea, vomiting, anorexia, and abdominal pain. It can be deadly for some adults.

"Children and young adults do fairly well," he said. "But for anyone over the age of 49, the mortality is up to 3%-4%. This is a disease that can take lives."

If middle-aged adults are infected, this form of hepatitis can be devastating and costly, he said. There are more than 63,000 symptomatic infections in adults each year, resulting in 8,403 hospitalizations and 255 deaths. The illness results in 829,000 work loss days, 7,466 years of life lost at an annual cost of \$489 million.

"The bottom line is the vaccine is cost effective when you look at the implications," Dr. Balistreri said.

Part of the problem is that 80% of children excrete the virus for 3 weeks, some as long as 6 weeks. This results in adults, who are hit much harder by the symptoms, being susceptible to the virus. "Not only are children not symptomatic, but they continue to excrete the virus," he said. "No individual is sick at the time they are shedding."

Something as simple as eating a school lunch can result in an outbreak, as evidence of the Michigan outbreak in 1997 shows, when strawberries contaminated in Mexico and processed in California were then shipped to the school lunch program in Michigan.

Children play a vital role in the spread of hepatitis A virus, which can be transmitted through food, fecal matter, and person-to-person contact.

"We need to use a vaccine not only to protect the individual but the community, so it can't gain a foothold," Dr. Balistreri said.

Once an outbreak occurs then immunoglobulin can be given to prevent symptomatic infection in contacts. While there is nothing wrong with this, the timing is off, Dr. Balistreri said. Prevention appears to be the most effective approach.

A Thailand study of 40,119 school-aged children showed the vaccine was effective in immunizing children against hepatitis A. Of the 19,037 children given the vaccine, 94% developed antibodies in 8 months and 99% developed antibodies at 17 months. There were 38 cases of clinical hepatitis A in the control group, compared with only 2 in the vaccinated children, both of whom were probably infected with the virus at time of vaccination.

Currently, hepatitis A vaccination is recommended for those with occupational risks, such as health care and day-care workers, travelers to endemic regions, children in high-rate communities, persons with chronic liver disease, those with high-risk behaviors, and transplant recipients or others who are immune depressed.

When it was found that Native American children had a fourfold higher rate, the children were vaccinated, he said. That rate dramatically dropped after vaccinations were provided in 1996. Three years later, children in 11 Western states—where the incidence of hepatitis A was twice the national average—were targeted.

"It did a great job in those states with a

high rate," he said, but the adjoining states then developed a higher incidence. "The virus shifted east. The virus doesn't respect state lines." That's the problem in only targeting high-risk groups, he said.

Health officials should learn from the experience of hepatitis B, he said, where targeting the high-risk groups did not result in a substantial reduction in the frequency of hepatitis B. "We lost 10 years because we didn't start off with a universal vaccination program," he said.

He gave an example of 244 migrant children tested in Florida; on average, half already had been infected. The numbers increased with age, with 34% of the 2- to 5-year-olds testing positive for hepatitis A antibodies and 81% of the 14-year-old and over group testing positive.

"In a community that wasn't targeted, about half of the children already had been infected," he said. "This is a missed opportunity."

The biggest impediments to universal hepatitis A vaccination in children include cost, addition of yet another vaccination to a complex schedule, and the rising fear among some parents about vaccination.

But the vaccine has proved both safe and cost effective, he said.

The vaccine costs \$11.15 a dose under federal programs and \$26 to \$30 per patient in private practice. Administration fees are about \$12 a dose.

"Children play an important role in the spread of hepatitis A," said Dr. Balistreri. "There already is an immunization schedule in place for children, whereas trying to get adults immunized is another story."

One solution may be a combined hepatitis A and B vaccine for children, he said. Currently, the combined vaccine is approved for children in Europe, but approved only for adults in the United States. ■