ProQuad Shortfall Should Persist Until Next Year

BY ELIZABETH MECHCATIE
Senior Writer

As of mid-June, stocks of ProQuad were depleted because of manufacturing issues, and the combination vaccine was not expected to be available for the rest of the year, according to the Centers for Disease Control and Prevention. ProQuad is the combined attenuated live virus vaccine that contains measles, mumps, rubella, and varicella viruses—the components of the M-M-R II and varicella (Varivax) vaccines. Because of lower-than-expected yields of varicella-zoster virus (VZV), which is used to manufacture the Varivax, zoster (Zostavax), and ProQuad vaccines, their manufacturer, Merck & Co., had prioritized the production of Varivax and Zostavax over that of ProQuad. Then production of VZV bulk was temporarily suspended because of low yields.

The reduced supply of ProQuad was first announced in the CDC's Morbidity and Mortality Weekly Report (2007; 56:453), which said that Merck had notified the CDC in February about the problem, and notified the CDC in May that projections of ProQuad orders indicated that the vaccine would no longer be available as of July, "although timing will depend on market demand." Physicians can use M-M-R II and Varivax instead of ProQuad, according to the CDC notice.

It is expected that there will be an adequate supply of these vaccines to fully implement the recommended immunization schedule for varicella vaccine for all age groups and for the recommended use of zoster vaccine. For Varivax, this includes the routine two-dose schedule for children aged 12-15 months and 4-6 years; catch-up vaccination with the second dose for children and adolescents who received only one dose; and vaccination with two doses for other children, adolescents, and adults with no evidence of immunity. ■

Blood Infection Prevention Tips Underutilized

DALLAS — Fewer than half of U.S. hospitals—with the notable exception of those in the VA system—utilize all three widely recommended practices for preventing central venous catheter–associated bloodstream infections, according to a national survey.

The survey showed that 62% of Veterans Affairs hospitals take a comprehensive approach to prevention of central venous catheter–associated bloodstream infections, utilizing all three preventive practices. That's true of only 44% of the nation's non-VA hospitals, Dr. Sanjay Saint reported at the annual meeting of the Society of Hospital Medicine.

He and his colleagues conducted a survey of catheter-associated infection prevention practices at all 119 VA medical centers and a random national sample of more than 400 nonfederal hospitals with more than 50 beds and an ICU.

Guidelines strongly recommend three proven preventive strategies. Yet until now there have been no national data characterizing the extent to which hospitals are using them, which was the impetus for the survey, explained Dr. Saint of the University of Michigan, Ann Arbor.

The three key evidence-based preventive practices are use of maximal sterile barrier precautions, routinely employed in 84% of VA and 71% of nonfederal hospitals; chlorhexidine gluconate as an injection-site antiseptic, utilized in 91% of VA and 69% of non-VA hospitals; and avoidance of routine central line changes.

The survey also included semistructured telephone interviews with hospital infection control officers and on-site visits to identify barriers to implementation of the preventive practices. Among the most commonly cited barriers were "organizational constipators," Dr. Saint's term for mid- to high-level managers resistant to change.

Factors identified as conducive to use of the three preventive strategies included a hospital culture that places a premium on patient safety, encouragement of multidisciplinary infection prevention collaboratives, and having a champion of evidence-based change, which in most cases was an intensivist. That's a role hospitalists could fill as well, Dr. Saint observed.

—Bruce Jancin

Pages 22a—22b