Updated CDC Recommendations for the Use of Varicella Zoster Immune Globulin

CDC’s “Updated Recommendations for Use of Varizig—United States, 2013” was published in the July 19 issue of MMWR and is reprinted below:

The decision to administer Varicella Zoster Immune Globulin (Varizig) depends on three factors: 1) whether the patient lacks evidence of immunity to varicella, 2) whether the exposure is likely to result in infection, and 3) whether the patient is at greater risk for varicella complications than the general population.

Timing of Varizig administration. CDC recommends administration of Varizig as soon as possible after exposure to varicella-zoster virus and within 10 days. For high-risk patients who have additional exposures to varicella-zoster virus ≥3 weeks after initial Varizig administration, another dose of Varizig should be considered.

Patient groups for whom Varizig is recommended. Patients without evidence of immunity to varicella who are at high risk for severe varicella and complications, who have been exposed to varicella or herpes zoster, and for whom varicella vaccine is contraindicated, should receive Varizig. Patient groups recommended by CDC to receive Varizig include the following:

- Immunocompromised patients without evidence of immunity.
- Newborn infants whose mothers have signs and symptoms of varicella around the time of delivery (i.e., 5 days before to 2 days after).
- Hospitalized premature infants born at ≥28 weeks of gestation or who weigh ≥1,000 g at birth, regardless of their mothers’ evidence of immunity to varicella.
- Pregnant women without evidence of immunity.
- VariZig can be ordered from the exclusive US distributor, FFF Enterprises (telephone: 800-843-7477, or online at www.fffenterprises.com). For the full Varizig recommendations, go to www.cdc.gov/mmwr/pdf/ww/mm6228.pdf.

Vaccines and Guillain-Barré Syndrome (GBS)

A report of a large retrospective study (1995-2006) covering more than 30 million person years found that Guillain-Barré Syndrome (GBS) was not associated with vaccination, including influenza vaccination. The report appeared in the July 15, 2013, issue of Clinical Infectious Diseases. Researchers identified 415 confirmed GBS cases in the study period; 25 were found to have received any vaccination during the 6 weeks prior to onset of GBS. They compared the odds of vaccination in the 6 and 10 weeks before onset of GBS to the odds of vaccination during the same time intervals in all vaccinated individuals in the entire Kaiser Permanente Northern California population. No cases of GBS were found resulting from vaccines mainly given in childhood, including oral polio, MMR, PCV, LAIV, Hib, DTaP, varicella, and DTP-Hib. Researchers indicated their study had limited power due to the rarity of GBS cases. An abstract of the study is available at http://cid.oxfordjournals.org/content/57/2/197.abstract.

NIS-Teen Reports on HPV Vaccination Coverage in US

A July 26, 2013 MMWR report (www.cdc.gov/mmwr/preview/mmwrhtml/mm6229a4_e.htm?s_cid=mm6229a4_e) summarizes national HPV vaccination coverage levels among adolescent girls aged 13–17 years through NIS-Teen, and presents national post-licensure vaccine coverage monitoring findings. The report presents analysis of 2007–2012 National Immunization Survey-Teen (NIS-Teen) data, which demonstrated that although vaccination coverage with ≥1 dose of any HPV vaccine increased from 25.1% in 2007 to 53.0% in 2011, coverage in 2012 (53.8%) was comparable to 2011. Researchers determined that if missed opportunities were eliminated, the vaccination coverage rate for ≥1 dose of HPV vaccine could have reached 92.6%.

Researchers defined a missed opportunity as a healthcare encounter taking place on or after a girl’s 11th birthday and on or after March 23, 2007 (the publication date of ACIP’s HPV4 recommendation), during which a girl received at least one vaccine but did not receive HPV vaccine. The percentage of unvaccinated girls with at least one missed opportunity for HPV vaccination increased from 20.8% in 2007 to 84.0% in 2012. Among parents who did not plan to vaccinate their daughters in the next 12 months (23% of respondents), the top reasons given were: the vaccine was not needed (19.1%), the vaccine was not recommended (14.2%), concerns about vaccine safety (13.1%), lack of knowledge about the vaccine or the disease (12.6%), and daughter is not sexually active (10.6%). Despite low coverage, another national study shows HPV vaccination is helping to reduce HPV infection rates in teen girls. The study, presented in the June 19, 2013 edition of the Journal of Infectious Disease, found that, despite low HPV vaccine uptake since its introduction in 2006, vaccine-type HPV infection rates vaccine-type HPV.
THE “MIN/MAX” FUNCTION

Chances are you are using a thermometer that can monitor minimum and maximum temperatures. Public Health has distributed MIN/MAX thermometers to VFC-enrolled practices on two occasions, and new enrollees receive one as part of the orientation process. The MIN/MAX function can give you an indication of what your refrigerator (or freezer) has been doing while the clinic was closed. Using the MIN/MAX feature is recommended, but is not yet required. Here are some tips for making the most of your MIN/MAX thermometer.

- CLEAR THE MEMORY: The MIN/MAX tracking will cover any period of time you choose—overnight, over a weekend, an entire week. To measure a specific time period, clear the memory by pressing down on the MIN/MAX button; DeltaTrak model #12213 will beep twice when it is clear; DeltaTrak model #12215 does not beep but the screen will clear. The model number is on the back of the thermometer panel. If you are using other brands, such as Fisher Scientific, check the user’s manual. A cleared memory begins tracking from that moment until you check the readings and clear the memory again.

- GET THE READINGS: When the clinic reopens, get your readings by pressing the MIN/MAX button once for MAX temperature and again for MIN temperature. We have posted a new temperature log on the Public Health VFC webpage at www.kingcounty.gov/healthservices/health/communicable/immunization/vfc.aspx which provides space for noting these ranges. Be sure to exit the MIN/MAX function by pressing the button a third time. During normal temperature monitoring, the words MIN and MAX should not appear onscreen.

- DON’T FREAK OUT: If either the MIN or the MAX reading is out of range, contact Public Health at vfcinfo@kingcounty.gov or (206) 296-4774. We can help determine if your vaccine has been compromised. This is especially important for temps below 35°F (2°C). Temps above 46°F take longer to cause harm, but should also be dealt with quickly.

REFRIGERATORS and WEATHER: During the workday, the refrigerator responds to changes in its environment by releasing more or less cold air into the compartments. Ideally, this is not too noticeable because the clinic’s heating-ventilation-air conditioning (HVAC) system keeps the room temperature fairly consistent. When the clinic is closed, however, the HVAC is usually turned off. In the summertime this means that the clinic can get warmer at night than it was during the day. Household refrigerators are generally slower to respond to environmental temperature changes. Therefore, you may see MAX temps at 48-58°F following warm, sunny days. This is because the refrigerator could not keep up with the warming building. In most cases, this is a brief period of time and then the refrigerator’s cooling system kicks in (albeit a little late). The same can be true with clinics getting colder in the winter, when closed, once the HVAC is shut off—the refrigerator keeps working at the level it needed to during the day and gets too chilly. Temperatures near freezing are a much more serious matter for vaccine viability. Refrigerators that frequently show out-of-range MIN/MAX temperatures need adjustment, repair or replacement.

Return Service Requested

Continued from page 1, NIS-Teen Reports on HPV Vaccination

infection rates among 14-19 year old girls decreased by 56% between 2007-2010, compared to the pre-vaccine era 2003-2006. There were no significant differences in vaccine-type HPV prevalence among females of other age groups during the study periods. The authors report vaccine effectiveness for one dose of HPV vaccine at 82% (95% CI – 53-93), and conclude that the significant decrease in HPV infection rates among 14-19 year old girls indicates high vaccine effectiveness for that age group. The complete article can be found at http://jid.oxfordjournals.org/content/208/3/385.full.pdf+html?sid=f04830b8-cf89-4319-812e-c926e0e9ad0.