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Influenza Season

As summer comes to an end, influenza season draws closer. To reduce the occurrence of influenza and its complications, preparations begin now to protect the most vulnerable people in the population. In this article, we highlight the most important changes to influenza vaccination recommendations as reported in the Morbidity and Mortality Weekly Report, "Prevention and Control of Influenza, Recommendations of the Advisory Committee on Immunization Practices (ACIP)" (46:No. RR-9, April 25, 1997).

Each year the composition of the influenza vaccine changes based on information collected from influenza surveillance data. The vaccine for the 1997-98 season will include A/Bayern/07/95-like (H1N1), A/Wuhan/359/95-like (H3N2), and B/Beijing/184/93-like antigens.

Groups at increased risk for influenza-related complications are:

- persons ≥65 years of age
- residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions
- adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma
- adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases, renal dysfunction, hemoglobinopathies, or immunosuppression
- children (≥6 months) and teenagers who are receiving long-term aspirin therapy
- women who will be in the second or third trimester of pregnancy during the influenza season

The Centers for Disease Control and Prevention has added as a target group women who will be in the second or third trimester of pregnancy (>14 weeks gestation) during the influenza season. A recent study revealed an increase in rates of hospitalization for influenza complications in pregnant women that were comparable to rates for people who have high risk medical conditions for whom influenza vaccination has been recommended. Pregnant women who have medical conditions which increase their risk for complications should be immunized against influenza irrespective of the stage of pregnancy. Many experts consider influenza vaccination at any stage to be safe, although some experts prefer to immunize pregnant women after 14 weeks gestation to avoid coincidental association of the vaccine with early pregnancy loss.

Most HIV infected individuals who have relatively high CD4+ counts (>200-300) will develop a protective level of antibody to influenza. Some recent studies have demonstrated a transient increase in the replication of HIV-1 lasting two to four weeks after influenza vaccination, while other studies have not demonstrated any substantial increase in viral replication. There is no evidence that an influenza vaccination will lead to a deterioration in CD4+ cell counts or that it will cause the progression of HIV disease. Vaccination will benefit many HIV-infected individuals. As an adjunct to vaccination, chemoprophylaxis with amantadine or rimantadine can be considered. However, these patients should be monitored closely for medication side effects and drug interactions.

Rates of vaccination among those at high risk who are <65 years of age is estimated to be less than 30%. However, vaccination levels among persons ≥65 years increased substantially from 1985 (23%) to 1994 (55%). Increasing rates of influenza immunization among senior adults has been attributed to an increase in preventive messages targeted to seniors and improved access to influenza vaccinations.

Each year the Seattle-King County Department of Public Health (SKCDPH) participates in the national influenza surveillance system. Surveillance activities begin October 1 and continue through March, or until the influenza season is over, whichever is longer. As a part of this surveillance system, a volunteer group of sentinel local health care providers agrees to send serologic specimens and viral throat cultures to the SKCDPH laboratory. This helps to establish the influenza strains that are circulating in the community and whether antiviral agents will be helpful for those patients who are at highest risk. We do need volunteers again this year. SKCDPH provides specimen collection kits and the laboratory testing done by our laboratory is free of charge to you. If you are interested, please call Eric Winder at (206) 296-4774. The SKCDPH will begin offering influenza vaccine to the public on October 13, a week earlier than last year.

Hepatitis A Vaccine

Just a few years ago, our only available responses to prevent hepatitis A virus (HAV) infection were to counsel travelers about safe handling of food and water and administer immune globulin (IG) before they traveled, or to give IG prophylaxis in the case of HAV exposure. While these measures are still very important, we can now protect groups at risk for HAV infection before an exposure occurs with a two-dose series of hepatitis A vaccine.

Two hepatitis A vaccines are licensed and approved for use in the United States: Havrix® (SmithKline Beecham Biologicals), and Vaqta® (Merck Research Laboratories). Both vaccines contain inactivated virus produced in human fibroblast cell culture.

Havrix® is available in 3 formulations (2 pediatric and one adult) and Vaqta® has one formulation (without a preservative) for both children and adults. The administration schedule for children aged 2 through 18 years with Havrix® 360 EL.U requires three doses (initial, one month, and 6-12 months later). The remaining vaccines require only two doses (initial and 6-12 months later); the Vaqta® pediatric schedule allows for the second dose to be administered as late as 18 months later.

No serious adverse events attributed definitively to hepatitis A vaccine have been reported in children or adults. As with any vaccine given intramuscularly, the most common side effect is soreness at the injection site. Both vaccines can be used interchangeably to complete a series. Protective antibody levels develop within two weeks of a single dose of hepatitis A vaccine. The second dose of the series ensures longer-term protection. Since hepatitis A vaccines have been under evaluation for only a short time, it is not known whether booster doses may be needed in the future.

Groups at **highest** risk for HAV infection who should be immunized include:

- travelers to countries with intermediate or high endemic rates of HAV
- children in communities with high rates and/or periodic outbreaks of HAV (e.g., Native Americans or Alaskan Natives)
- men who have sex with men
- illegal-drug users
- persons with chronic liver disease
- persons with clotting factor disorders
- persons with occupational risk for HAV infection

State supplied vaccine (currently Havrix®-720) is available for children 2 through 18 years in specific high risk groups. For more information, contact the SKCDPH Immunization Program at (206) 296-4774.

1997 Red Book

The 1997 Red Book:The Report of the Committee on Infectious Diseases has recently been published by the American Academy of Pediatrics (AAP), replacing the 1994 Red Book. The Red Book gives current recommendations and guidelines for prevention, control, and management of infectious diseases in infants and children. A summary of the major changes is given in the Red Book and also published in *Pediatrics* (July 1997). Subsequent AAP recommendations are published in *AAP News* and *Pediatrics*. The major changes include a new immunization schedule and guidelines; hospital infection control; recent information on *E. coli* O157:H7, hepatitis A, B, and C, HIV infection and related opportunistic infections, Ehrlichiosis, and Group B streptococcal infections; new immunization recommendations for measles, pertussis, polio, Varicella-Zoster, pneumococcal, and rabies; and new treatment guidelines for malaria, invasive pneumococcal, RSV, TB, and *Pneumocystis carinii* infections. New chapters and tables have also been added on topics such as school health, bite wounds, Chancroid, STD treatment guidelines by syndrome, and foodborne diseases. Health care providers involved in the care of children will find this book most helpful.

To Report:
AIDS 296-4645
Tuberculosis 296-4747
STDs..... 731-3954
Communicable Disease 296-4774
24-hr Report Line..... 296-4782
Disease Alert:
CD Hotline 296-4949

REPORTED CASES OF SELECTED DISEASES
SEATTLE-KING COUNTY 1997

	CASES REPORTED IN AUGUST		CASES REPORTED THROUGH AUGUST	
	1997	1996	1997	1996
VACCINE-PREVENTABLE DISEASES				
Mumps	0	0	3	2
Measles	0	0	1	4
Pertussis	10	27	136	156
Rubella	0	0	1	2
SEXUALLY TRANSMITTED DISEASES				
Syphilis	1	0	5	0
Gonorrhea	79	47	559	664
Chlamydial infections	210	210	2013	2288
Herpes, genital	60	36	441	469
Pelvic Inflammatory Disease	27	35	203	266
Syphilis, late	2	5	32	47
ENTERIC DISEASES				
Giardiasis	29	27	160	147
Salmonellosis	21	18	147	151
Shigellosis	9	6	71	41
Campylobacteriosis	43	34	227	219
E.coli O157:H7	10	14	27	25
HEPATITIS				
Hepatitis A	48	51	316	214
Hepatitis B	5	2	30	61
Hepatitis C/non-A, non-B	2	0	11	10
AIDS	12	27	209	319
TUBERCULOSIS	9	10	97	96
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae	0	0	1	3
Meningococcal disease	1	0	15	20