

Measles

Blenheim had the first confirmed case of measles this month since 2009. The way the case was handled reduced the chance of spread within the local community and our MOH would like to highlight how well this was done:

- A member of the infant's family knew to warn the clinic staff ahead of bringing the infant into the clinic
- The infant was kept in the car until the child could be taken directly into a room
- Excellent history was then taken which indicated:
 - prodrome followed by typical rash and persisting fever, and a history of travel from area with a known ongoing outbreak (Auckland)
- Correct swabs taken (nasopharyngeal and throat swabs into same viral transport media)
- Vaccination status of household contacts was ascertained and asymptomatic sibling aged 3 years was offered and given (early 4 year old) MMR immediately
- Room linen was cleaned and not used for rest of evening
- Public Health was notified "on suspicion" so they could immediately reinforce need for isolation, check for other susceptible contacts and offer vaccination within 72 hours of exposure (fortunately there were none).

Hats off to the team at Marlborough AfterHours GP Service! from Dr Jill Sherwood, Medical Officer of Health

IMAC Resources

The following resources are available on the IMAC website: www.immune.org.nz

These are great for expanding your vaccination knowledge and dealing with some of those difficult questions.

- **Comparisons of effects of disease and vaccines**

This information considers and evaluates the seriousness of a disease compared to potential risks of a vaccination.

- **Quick answers to frequent MMR questions**

As the title suggests, gives consolidated and concise information about the MMR vaccine.

- **Vaccine ingredients**

This resource lists vaccine ingredients, how common they are and where we might find them in our daily life.

- **Duration of immunity provided by each vaccine**

Key points cover common vaccine definitions of immunogenicity, efficacy & herd immunity - easy to follow.

- **Pre-term and low birth weight infants**

Good resource in the event of a healthy premature baby coming in needing follow up scheduled immunisations.

- **Management of tetanus prone wounds**

Updated 'tetanus prone' wound flowchart to clarify ongoing queries for tetanus prone injuries.

- **Administration of early or expired vaccines**

Offers guidelines around early administration of vaccine; how early is too early and recommendations in the event of administration of an expired vaccine or diluents.

Informed consent

Health professionals have legal obligations to obtain informed consent prior to a procedure or data collection.

With regard to vaccination, the individual or parent/guardian needs to understand the benefits and risks of vaccination in order to make an informed choice and give informed consent.

The essential elements of the informed consent process are effective communication, full information and freely given competent consent.

Issues to discuss with parents/individuals about immunisation at each episode include:

- The vaccine preventable diseases.
- The vaccines used on the schedule.
- How vaccines work, known risks and adverse events, & components of the vaccine (in case of allergies).
- The collection of immunisation information on the NIR.
- The choice to vaccinate.

Presentation for immunisation should not be interpreted as implying consent. (Ref: 2011 Immunisation Handbook p 51-54)

VACCINATOR CHECKLIST

Prior to immunisation with any vaccine, the vaccinator should ascertain if the vaccinee (child or adult):

- Is well today – assess.
- Does not has a fever over 38°C.
- Has ever had a severe reaction to any vaccine –assess.
- Has any severe allergies to vaccine components eg gelatin, neomycin, egg protein.
- Has a history of a severe allergic reaction from any cause.
- Is not pregnant (if applicable) or anticipating pregnancy.
- Does not have an undiagnosed or evolving neurological condition.
- Has appropriate spacing between doses of the same vaccine (what/when was the last vaccination).

Prior to giving a live vaccine eg MMR, Varicella, the vaccinator should also ascertain the vaccinee:

- Has not had a vaccine containing live viruses with in the last month eg MMR, Varicella.
- Has not had an injection of immunoglobulin or blood transfusion in the last 11 months (note: deferral time is shorter for some blood products and immunoglobulin – see Table 1.5).
- Is not taking corticosteroids, eg prednisone, or other immune suppressive drugs.
- Does not have lowered immunity eg due to leukaemia, AIDs, or is on treatment eg radiotherapy which lowers immunity and the immune response.
- Does not live with someone with a disease or treatment which lowers immunity.

(Reference 2011 Immunisation Handbook -Table 1.5 page 36, and pg 56-57)

Post vaccination advice

Post vaccination advice should be given both verbally and in writing and should cover:

- Which vaccines have been given, the injection sites and whether they were IM or SC.
- Common vaccine responses following immunisation and what to do if these occur.
- When to seek medical advice.
- Contact phone numbers including Afterhours.

(Reference 2011 Immunisation Handbook pg 66)

Odds and ends

When administering Hepatitis B, IPV (IPOL) or dTap (Boostrix) to any person who is not eligible for a funded vaccine (as per pg 4,5,22 and back cover of 2011 Immunisation Handbook) it must be privately purchased (not taken from your funded vaccine stock) by ordering on the “Healthcare Logistics Non Funded Vaccines” order form.

Adrenaline administration: When administering adrenaline it is best delivered into a large muscle as a deep IM injection, the most common site being the vastus laterals. If this is not possible then adrenaline must be delivered with 2cm spacing between vaccine and adrenaline. The use of the deltoid in a young child or infant is not best practice. It is important to use alternate sites/limbs for additional doses as tissue necrosis can occur if the same injection site is used repeatedly.

Oxygen therapy in Anaphylaxis: The recommended oxygen dosing in an event of anaphylaxis is “high flow rate” (pg. 69 2011 Immunisation Handbook). High flow rate is 10 L/min as advised by Dr Nikki Turner, Director of the Immunisation Advisory Centre (IMAC)

Expelling Air from Vaccine syringes: IMAC confirm:

Only when administering vaccines where the needle is fixed, ie. Influenza, Polio (IPV brand), should the air not be expelled from the syringe. This prevents the potential of expelling some of the vaccine and in turn tracking the vaccine through the skin.

(Reference 2011 Immunisation Handbook pg. 410)

All other vaccines require the air to be expelled and the needle changed before administration. When mixing and drawing up a vaccine, remove drawing up needle, expel air and bring vaccine to the base of the hub on the syringe, put on giving needle. Or where a needle is to be attached, expel air and bring vaccine to the base of the hub on syringe, put on giving needle.

I am on leave from Friday the 23rd December returning on Wednesday the 4th of January. Any urgent vaccination queries please call the Immunisation Advisory Centre on 0800 466 863.

MERRY CHRISTMAS