

Immunisation Guidelines for Ireland

Corrections, August 2010, Edition

Since the publication of the Immunisation Guidelines for Ireland, 2008 edition, the following changes have been made. The changes will appear in the online versions of the guidelines. The changes will NOT appear in the printed version of the guidelines until the next edition.

[New chapter added - Human Papillomavirus - Chapter 6a.](#)

This can be found directly after chapter 20 in the complete online edition and after chapter 6 in the individual chapters section online.

[New chapter added – Pandemic Influenza – Chapter 10a](#)

This can be found after chapter 10 only in the individual chapters section online.

Page	Chapter	Statement 2008 Edition	Updated statement	Rationale for change
II	Preface and Anaphylaxis	Note 5. Half doses of adrenaline may be safer for patients on amitriptyline, imipramine or beta-blocker	Removal of note 5.	Correction: See clarification page IV.
III	Preface and Anaphylaxis	Note 4. Half doses of adrenaline may be safer for patients on amitriptyline, imipramine or beta-blocker	Replace Note 4. If a patient on beta-blockers has not improved after 2-3 doses of Adrenaline, consider giving Glucagon, 2-3 micrograms/kg (max. 1-2mgs) IV over 5 minutes, IV salbutamol, and/or IV atropine.	Correction: See clarification page IV
IV	Preface and Anaphylaxis	No statement	A number of drugs may interfere either with the action of Adrenaline (Epinephrine) or with the compensatory mechanisms, which occur in anaphylaxis. These drugs include beta-blockers, tricyclic antidepressants, ACE inhibitors, and Angiotensin 2 receptor blockers. As anaphylaxis is a life-threatening event, the benefits of giving the recommended doses of Adrenaline outweigh potential risks. Adrenaline doses should be titrated according to their effect. If a patient on beta-blockers has not improved after 2-3 doses of Adrenaline, consider giving Glucagon, 2-3 micrograms/kg (max. 1-2mgs) IV over 5 minutes, IV salbutamol, and/or IV atropine. These should only be used in hospital, preferably under the supervision of an intensivist	Clarification given for corrections on pages II and III.

14	2. General Immunisation Procedures	Table 2.2	Table 2.2 updated	Change to guideline based on changes in vaccination preparations available in Ireland. Clarifications in relation to intervals between doses. Addition of BCG to table as it is recommended that it be included in catch up vaccination.
15	2. General Immunisation Procedures	Table 2.3	Table 2.3 updated	Change to guideline based on changes in vaccination preparations available in Ireland. Addition of BCG and Men C to table as these are recommended to be included in catch up vaccination. Correction:Hepatitis B removed from table as Hepatitis B vaccination is not routinely recommended as part of catch up programme in this age group.
16	2. General Immunisation Procedures	No statement	BCG BCG should be given to low risk children up to 15 years of age and specified high risk children and adults up to 35 years of age, who do not have documented evidence of BCG vaccination and who do not have a characteristic BCG scar and who are tuberculin (or interferon gamma) negative (see Chapter 16 for indications re tuberculin test and specified risk groups).	Addition of BCG as this is recommended as part of catch up vaccination.
16	2. General Immunisation Procedures	MMR: Because adverse reactions to the MMR vaccine are rare, two doses should be given at 12 months and 4-5 years of age (or at least 4 weeks apart if aged >4 years) unless there is a very reliable history of previous vaccination. Serological testing may be carried out if there are well-founded concerns about revaccination.	MMR Because adverse reactions to the MMR vaccine are rare , two doses should be given at 12 months and 4-5 years of age (or at least 1 month apart if aged over 4 years) unless there is a documented history of 2 previous vaccinations. If in doubt, it is preferable to give an extra MMR vaccine. If a child aged <18 months receives a second MMR vaccine within 3 months of the first MMR, a third MMR should be given at 4-5yrs of age.	Deletion of recommendation re serology testing as adverse reactions to MMR vaccine are rare and so it is recommended to give two doses of MMR unless there is documented evidence of 2 previous vaccinations. Additional recommendation to give a third dose of MMR if the second was given at less than 18 months and within 3 months of the first MMR due to poorer immune response before this age.

16	2. General Immunisation Procedures	DTaP: More than 4-5 doses of each of the components may very occasionally result in severe local (Arthus) reactions if given without regard to appropriate intervals.-	Diphtheria, Tetanus, Pertussis More than 4 -5 doses of vaccines containing diphtheria, tetanus or pertussis antigens may very occasionally result in severe local (Arthus) reactions if given more frequently than recommended.	Clarification: DTaP may very occasionally result in a severe local (Arthus) reaction if given more frequently than recommended.
16	2. General Immunisation Procedures	HepB: A three-dose series may be given to children who are unvaccinated, as per the Irish recommendations.	Hep B A 3 dose series (as part of a 6 in 1 vaccine) may be given to unvaccinated children up to the age of 10 years. A 3-dose series of Hepatitis B vaccine may be given to children >10 years and adults who are unvaccinated, if required, as per the Irish recommendations for targeted immunisation.	Clarification: Hep B vaccination can be given as part of 6 in 1 to children less than 10 years and can be given as a single vaccine to those over 10 years, if required, as per Irish recommendations for targeted immunisation.
18	2. General Immunisation Procedures	Note 3 added to table.	Note 3. See page 20. May need to seek medical guidance from treating physician.	Clarification: If in doubt as to the level of immunosuppression following reading of page 20, you may need to discuss with treating physician.
25	2. General Immunisation Procedures	Hepatitis B vaccine may not give an adequate immune response in infants less than 2kg, and should be deferred until the infant is more than 2kg, unless the mother is HBsAg positive. In this case the infant should receive a birth dose and three further doses at 2, 4 and 6 months of age.	Hepatitis B vaccine may not give an adequate immune response in infants weighing less than 2kgs, until they are aged one month. However, if a mother is HBsAg positive, her infant should be given the HepB vaccine at birth and further doses (as 6-in-1 vaccine) at 2, 4 and 6mths.	Clarification: Hep B vaccine may not be effective until baby is 2 kgs of weight or aged one month. However, if a mother is HBsAg positive the vaccine should be given at birth (regardless of weight) and further doses at 2,4 and 6 months.
32	2. General immunisation procedures	The BCG is given into the skin at one site over the middle of the deltoid muscle; tuberculin is generally injected into the ventral surface of the forearm.	The BCG is given into the skin at one site over the distal insertion of the deltoid muscle (approx. one third down the upper arm); tuberculin is generally injected into the ventral surface of the forearm.	Correction: BCG should be given at the distal insertion of the deltoid muscle.

34	2. General immunisation procedures	No statement.	<p>It is recommended that:</p> <p>1. Prophylactic antipyretics should not routinely be given at the time of vaccination. Either paracetamol or ibuprofen may be considered for treatment of fever >39.5C or for a significant reaction at the site of vaccination.</p> <p>2. Parents or vaccinators should consider administering glucose or sucrose solutions of 24-30% or greater concentration to infants immediately before vaccination.</p>	<p>Addition: Recommendation based on findings in relation to the use of analgesics, antipyretics and sweet solutions on pain and vaccine response.</p>
39	3. Diphtheria	<p>The first booster dose may be given 1 year after the third dose, and the second booster 10 years after that.</p> <p>If a person is at increased risk the second booster dose may be given 5 years later.</p>	<p>The first booster dose should be given 5 years after the third dose and the second booster dose 10 years after that.</p> <p>Sentence deleted.</p>	<p>Correction: The first booster dose should be given 5 years, rather than 1 year after the 3rd dose and the second booster 10 years after that regardless of whether at increased risk or not.</p>
52	5. Hepatitis A	Travellers, including children one year and over, to endemic areas.	Travellers, including children one year and over, to areas with high or intermediate hepatitis A endemicity.	<p>Clarification: Re areas of endemicity.</p>
53	5. Hepatitis A	No Statement.	Household members and other close personal contacts of adopted children newly arriving from countries with high or intermediated hepatitis A endemicity (see first bullet). Immunisation should preferably be offered before adoption.	<p>Addition: It is recommended that these contacts should receive pre-exposure prophylaxis based on epidemiological evidence.</p>

54	5. Hepatitis A	<p>However, information about the relative efficacy of vaccine compared with HNIG post-exposure is limited, and no data are available for persons aged over 40 years or those with underlying medical conditions.</p> <p>It is becoming increasingly difficult to access supplies of HNIG and therefore the use of HAV vaccine for healthy contacts aged 1 year to 40 years may be a viable alternative.</p>	<p>However, information about the relative efficacy of vaccine compared with HNIG post exposure is limited. For persons aged 40 years and over and those with underlying medical conditions, HNIG is still preferred because of the absence of information regarding vaccine performance and the more severe manifestations of hepatitis A in these groups.</p> <p>It is becoming increasingly difficult to access supplies of HNIG and therefore the use of HAV vaccine for healthy contacts aged 1 year to 39 years may be a viable alternative. For those aged 40 and over and those with underlying medical conditions, HAV vaccine can also be used if HNIG cannot be obtained.</p>	<p>Clarification: While HNIG should be used in those 40 years and over, and in those with underlying medical conditions, if it is not available HAV vaccine can be used.</p>
67	6. Hepatitis B	<p>Different HBV vaccine products can be used to complete a primary immunisation course or, where indicated, as a booster dose in individuals who have previously received another HBV vaccine.</p>	<p>Different HBV vaccine products can be used to complete a primary immunisation course or, where indicated, as a booster dose in individuals who have previously received another HBV vaccine.</p> <p>One of the licensed higher dose vaccine products (used for adult patients with chronic renal failure, and considered for other immunosuppressed adults) is not interchangeable.</p>	<p>New information: This is to highlight that there is a new vaccine available which is NOT interchangeable with the other vaccines,</p>
69	6. Hepatitis B	<p>Infants born to mothers who are HBV infected should be tested at 12 months of age to determine HBV status and post-vaccination response.</p>	<p>Infants born to mothers who are HBV infected should be tested 2 months after completing HBV immunisation to determine HBV status and post-vaccination response.</p>	<p>Correction: Infants should be tested 2 months after completing HBV immunisation, regardless of age.</p>
78	7. Influenza	<p>Vaccination is recommended for:...</p> <p>a) Persons aged 50 years or older as recommended by WHO.</p>	<p>Vaccination is recommended for:...</p> <p>a) Persons aged 50 years or older.</p>	<p>Clarification: This recommendation is based on review of scientific literature and was incorrectly attributed to WHO.</p>

78,79	7. Influenza	Vaccination is recommended for:	<p>Revised indications for seasonal influenza vaccine for 2010/2011</p> <ol style="list-style-type: none"> 1. Those older than 6 months of age who are at increased risk of influenza-related complications including the following groups: <ol style="list-style-type: none"> a) Persons aged 50 years or older b) Those with chronic illness requiring regular medical follow-up (e.g. chronic respiratory disease, including cystic fibrosis, moderate or severe asthma, chronic heart disease, bronchopulmonary dysplasia, diabetes mellitus, haemoglobinopathies, chronic renal failure, chronic liver disease, chronic neurological disease including multiple sclerosis, hereditary and degenerative disorders of the central nervous system etc.) c) Immunosuppression due to disease or treatment, including asplenia or splenic dysfunction d) Children on long-term aspirin therapy (because of the risk of Reyes Syndrome) e) Children with any condition (e.g. cognitive dysfunction, spinal cord injury, seizure disorder, or other neuromuscular disorder) that can compromise respiratory function especially those attending special schools/ day centres f) Those with morbid obesity i.e. Body mass index over 40g) 4. People who have close, regular contact with pigs, poultry or water fowl 5. Pregnant women in the risk groups 1b and 1c listed above should be vaccinated before the influenza season, regardless of the stage of pregnancy. Pregnant women not in the risk groups 1b and 1c who have not already received pandemic (H1N1) 2009 vaccine should be vaccinated at any stage in pregnancy. 	<p>Change: The revised recommendations are based on findings in relation to the behaviour of H1N1 influenza, which is likely to be the dominant influenza strain circulating during the 2010/2011 season.</p>
80	7. Influenza	Table 7.2	Table 7.2 updated.	<p>Change: Change to table to include recommendations for immunocompromised people and change of age groups from 3-12 years to 3-9 years.</p>

100	9. Meningococcal infection	Children who have not received a dose of MenC vaccine over 1 year of age, should be offered a booster.	Those who completed a course more than one year before should be offered a booster.	New information: Due to the potential for waning immunity, it is recommended to give a booster MenC vaccine to any close contact who completed their course of vaccination more than one year previously.
111,144,	10, 14 Mumps Rubella	When measles outbreaks occur, susceptible persons should be given MMR within 72 hours of contact with a case.	Deleted	Removal of section: Guidance on using MMR for contacts of measles has been deleted as MMR is not effective for contacts of mumps or rubella.
113,146	10, 14 Mumps Rubella	Protection of contacts with immunoglobulin.....	Section deleted	Removal of section: Guidance on using immunoglobulin for contacts of measles has been deleted as immunoglobulin is not recommended for use for contacts of mumps or rubella.
90,112,145	8,10,14, Measles, Mumps, Rubella	Precautions:.... 2. Infection with another live vaccine within the previous 3 weeks	Precautions: 2. Infection with another live vaccine within the previous 4 weeks	Correction: There should be a minimum interval of 4 weeks between live vaccines.

135	13. Poliomyelitis	<p>Unimmunised adults</p> <p>Incompletely immunised adults</p> <p>2. Live Oral Polio Vaccine</p>	<p>Unimmunised persons aged 10 years and over Three doses of an IPV containing vaccine 1 month apart, with a booster 5 years later, are recommended, as per Chapter 2.</p> <p>Incompletely immunised persons aged 10 years and over and fully immunised persons at increased risk of exposure The course should be completed with an IPV containing vaccine. Fully vaccinated persons aged 10 years and over at increased risk of exposure to wild poliovirus should be given a single dose of Td/IPV (or Tdap/IPV if indicated). An interval of at least 6 months should be left between doses 3 and 4. At-risk persons include:</p> <ul style="list-style-type: none"> • Those traveling where poliomyelitis is epidemic or endemic • Those in contact with patients who may be excreting wild poliovirus • Those in contact with specimens that may contain wild poliovirus <p>2. Live Oral Polio Vaccine (OPV) The risks of Vaccine Associated Paralytic Polio (VAPP) following OPV of approximately 1 case per 2.5 million doses are greater than the risks of wild poliovirus poliomyelitis except in those travelling to areas where polio virus is endemic. OPV is no longer licensed or available in Ireland.</p>	<p>Correction: The risks of Vaccine Associated Paralytic Polio (VAPP) following OPV of approximately 1 case per 2.5 million doses are greater than the risks of wild poliovirus poliomyelitis except in those travelling to areas where polio virus is endemic.</p> <p>OPV is no longer licensed or available in Ireland. Therefore all recommendations are changed to reflect recommendation of IPV use only in Ireland.</p>
-----	-------------------	--	---	---