Pull-out poster for Repiratory Hygiene Awareness Campaign and Halloween Safety Tips Inside

County of Los Angeles Department of Health Services
Public Health

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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Influenza 2004-05: New Vaccination Recommendations and the 2003-04 Season Summary

While years of surveillance have identified some common influenza trends (i.e., the general time of onset and peak), these trends are not absolute. Even core aspects can change in a given year, as was evident last season. Locally and nationally, the season peaked several weeks earlier than expected. Even more surprising and unusual was how widespread and simultaneously activity peaked; instead of peaking sequentially in states across the nation, last year nearly all states reported their peak activity at about the same, and earlier than expected.

While we cannot always predict what will occur during influenza season, we can prepare. Now is the time to ensure your patients are vaccinated—especially those at high risk for complications from influenza (i.e., the elderly and those with compromising medical conditions such as asthma or diabetes). In addition, now is the time to dispel prevalent myths and misconceptions about vaccination. For instance, vaccination is especially important for women who will be pregnant during flu season and for those who are immunocompromised (such as with HIV infection), yet these individuals often incorrectly assume they should avoid vaccination. The 2004-05 vaccine composition has been modified and is expected to be a good match for the viral strains in circulation. The full influenza vaccination recommendations are provided on pages 9 and 10.

For information on a flu vaccination clinic near you, call 1-800-427-8700 or visit www.lapublichealth.org/ip/flu/2004-2005.htm

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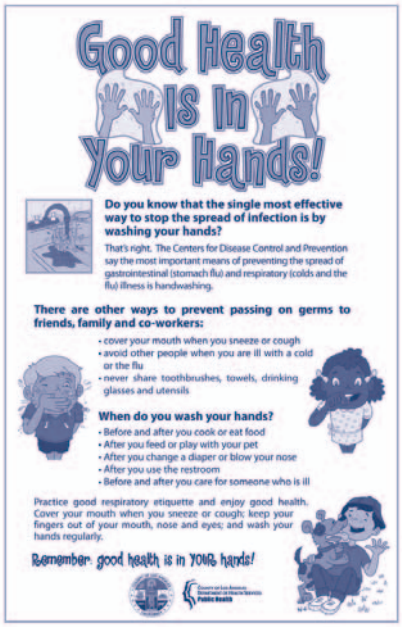
Respiratory Hygiene — Simple steps to avoid illnesses, save lives

Especially during cold and flu season, the importance of effective respiratory hygiene to reduce the spread of disease and illness cannot be overstated. Simple steps such as washing your hands and covering your mouth when you cough or sneeze yield enormous benefits in the fight against many illnesses. This fall, DHS is launching a Respiratory Hygiene Awareness Campaign to educate residents on the simple steps they can take to avoid spreading diseases. Enclosed is a poster for your use in waiting rooms and other clinic and office spaces.

Additional posters are available at www.lapublichealth.org/acd/index.htm or by calling Acute Communicable Disease Control (213) 240-7941



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CONTRIBUTORS TO THIS ISSUE:

David E. Dassey, MD, MPH
Deputy Chief, Acute Communicable Disease Control

Alvin Nelson El-Amin, MD, MPH
Medical Director, Immunization Program

Monica Murphy, RN, MSN
Director of Nursing, Immunization Program

REINSTATEMENT OF THE THIRD DOSE OF PNEUMOCOCCAL CONJUGATE VACCINE

Most providers should already be aware of CDC's reinstatement of the third dose of pneumococcal conjugate vaccine (PCV7) for healthy children. This dose had been deferred since March of this year due to production problems with the vaccine. However, the production problems appear to have been resolved so the third dose can now be given to children who would have normally been eligible to receive it.

Please be aware that healthy children who receive their first dose of PCV7 at less than 7 months of age will continue to have the fourth (booster) dose deferred. Also, healthy children 12-23 months of age who have not received any previous doses of PCV7 can now receive 2 doses, 2 months apart. At this time, PCV7 is still not recommended for healthy children 24-59 months of age.

Providers should continue to use the standard full-dose schedule to vaccinate all children at risk for invasive pneumococcal disease. In addition to the high-risk criteria listed in Table A, CDC recommends that Alaskan Native and American Indian children who live in Alaska, Arizona, or New Mexico, and Navajo children living in Colorado and Utah, also receive the standard full-dose schedule if they receive services at your facility.

Please refer to Table A which summarizes the current recommendations for all children, and Table B which gives a "catch-up" schedule for incompletely vaccinated children. If you have questions, please contact the Los Angeles County Immunization Program at (213) 351-7800.

TABLE A

UPDATED RECOMMENDATIONS FOR USE OF PNEUMOCOCCAL CONJUGATE VACCINE

Age at First Vaccination	Temporary Vaccination Schedule for Non-High-Risk Children	Vaccination Schedule for High-Risk Children
2-6 months	2, 4, 6 months (Defer 4th dose)	2, 4, 6, and 12-15 months
7-11 months	2 doses at 2-month interval; also 12-15 month dose	2 doses at 2-month interval; also 12-15 month dose
12-23 months	2 doses at 2-month interval	2 doses at 2-month interval
24-59 months	DEFER	2 doses

Revised Guidelines 2/2004: Providers receiving vaccine from the Los Angeles County Immunization Program must implement the "Temporary Vaccination Schedule for Non-High-Risk Children" above for all infants and children except children who are at high-risk for pneumococcal disease. Follow the "Vaccination Schedule for High-Risk Children" above for high-risk infants and children up to 59 months of age.

Children at high-risk for invasive pneumococcal disease include children with:

- sickle cell disease and other hemoglobinopathies,
- anatomic asplenia,
- chronic diseases (e.g., chronic cardiac and pulmonary disease and diabetes mellitus, renal failure, nephrotic syndrome),
- cerebrospinal fluid leak,
- human immunodeficiency virus (HIV) infection and other immunocompromising conditions, immunosuppressive chemotherapy or long-term corticosteroids use;
- children who have undergone solid organ transplantation; and
- children who either have received or will receive cochlear implants.

Please post next to 2004 Recommended Childhood Immunization Schedule

TABLE B

CATCH-UP SCHEDULE

AGE AT EXAMINATION (MOS.)	VACCINATION HISTORY	RECOMMENDED REGIMEN*
2-6	0 doses 1 dose 2 doses	3 doses, 2 mos. apart 2 doses, 2 mos. apart 1 dose, 2 mos. after the most recent dose
7-11	0 doses 1 dose before age 7 mos. 2 doses before age 7 mos.	2 doses, 2 mos. apart; third dose at age 12-15 mos. 1 dose at age 7-11 mos. with another dose at age of 12-15 mos. (≥2mos. later) 1 dose at age 7-11 mos.
12-23	0 doses 1 dose before age 12 mos. 1 dose at age ≥ 12 mos. 2 doses before age < 12 mos.	2 doses, ≥ 2 mos. apart 2 doses, ≥ 2 mos. apart 1 dose, ≥ 2 mos. after the most recent dose 1 dose, ≥ 2 mos. after the most recent dose
24-59 Healthy children Children at high risk[§]	 Any incomplete schedule of <3 doses Any incomplete schedule of 3 doses	Not routinely recommended† 1 dose, ≥ 2 mos. after the most recent dose and another dose ≥2 mos. later 1 dose, ≥ 2 mos. after the most recent dose

*For children vaccinated at age <12 months, the minimum interval between doses is 4 weeks. Doses administered at age ≥12 months should be ≥ 8 weeks apart.

† When the shortage is resolved completely, health-care providers should consider administering a single dose to unvaccinated, healthy children aged 24-59 months (with priority given to children aged 24-35 months), African American children, American Indian children not otherwise identified as high risk[§], and children who attend day care centers.

[§] Children with sickle cell disease, asplenia, chronic heart or lung disease, diabetes, cerebrospinal fluid leak, cochlear implant, human immunodeficiency virus infection (HIV) or other immunocompromising condition, and Alaskan Native or American Indian children in areas with demonstrated risk for invasive pneumococcal disease more than twice the national average (i.e., Alaska, Arizona, New Mexico, and Navajo populations in Colorado and Utah).

ADAPTED FROM MMWR 2004; 53 (26): 590

Influenza 2004-05: (from page 1)

A review of the 2003-04 influenza season: Was it really that bad?

During December 2003, the U.S. media depicted nationwide influenza activity as unusually and unexpectedly severe and deadly—and these fear-provoking reports instigated a ground swell of intense public anxiety and demand for vaccination.

However, the impending severity of the season wasn't entirely unexpected. As early as August 2003, there were indications that upcoming flu season would be especially severe based on reports of high activity occurring in the southern hemisphere (Australia and New Zealand) due to a novel type A viral strain. But despite warnings from health officials urging vaccination and preparation for flu season, initial interest was mild at best. No shortages, delays or staggered scheduling impacted vaccination—in fact, there was actually more vaccine available than previous seasons—and vaccination clinics proceeded with limited public demand.

Similarly, the debut of FluMist, a live attenuated influenza vaccine administered via a nasal spray, was a disaster; as of mid-November 2003, only 400,000 doses were sold to pharmacies and doctors' offices—a far cry from the manufacturer's forecasted sales of 4 to 6 million doses.

But by December, public interest in influenza changed dramatically. Beginning mid-November, the Colorado Department of Health began reporting a series of pediatric deaths associated with influenza. These received extensive media attention and were followed up by reports of additional deaths in other states.

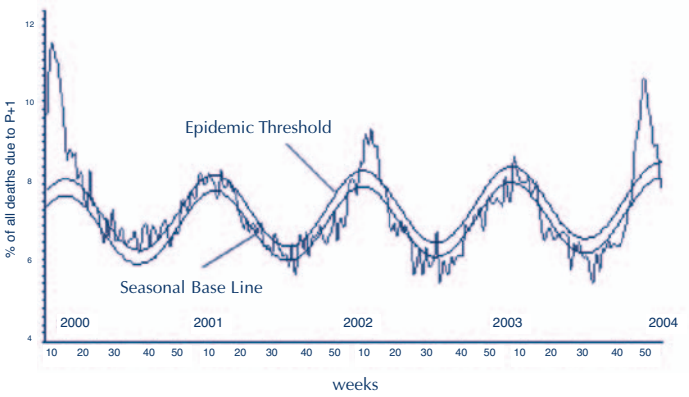
While deaths due to influenza occur every year, there was concern that this circulating viral strain was particularly virulent among pediatric cases. Accordingly, the CDC initiated a special research project for pediatric fatalities and intensive care cases with evidence of influenza infection. Around mid-December, public demand for vaccination reached an all-time high, and the sudden surge in people who desired vaccination caused long lines and shortages in many areas. Oddly, the surge in interest corresponded with the peak in cases both locally and nationwide; incident cases reached their highest level peaked during weeks 50–52. Influenza levels and corresponding public interest quickly declined in the New Year.

But was it really that bad? The indicators are mixed. An especially severe season was expected since the prevalent circulating viral strain was type A, which tends to yield higher levels of morbidity and mortality than type B strains. Plus, this viral strain was both novel and not represented by the season's vaccine—further increasing the likelihood of a severe season. As shown by the nationwide pneumonia and influenza mortality rates (Figure 1), a notable peak in deaths occurred during late 2003, especially as compared to the previous three seasons, which were very mild.

But while more severe than recent years, the overall mortality rate was actually comparable to if not milder than the previous type A season that occurred in 1999-00.

In Los Angeles County, mortality rates due to pneumonia and influenza were noticeably lower last season as compared to the 1999-00 season and comparable to recent seasons (Table 1).

Pneumonia and Influenza Mortality
for 122 U.S. Cities
week ending 02/28/2004



Continued on page 5

Influenza 2004-05: (from page 4)

Table 1: Pneumonia and influenza deaths by age group and influenza season.*

	Influenza Season**									
	1999-2000		2000-2001		2001-2002		2002-2003		2003-2004	
Age Group	no.	%	no.	%	no.	%	no.	%	no.	%
<1	7	0.3	8	0.5	7	0.5	4	0.3	2	0.1
1–4	0	0.0	1	0.1	2	0.1	1	0.1	3	0.2
5–14	1	0.0	0	0.0	0	0.0	2	0.1	2	0.1
15–24	0	0.0	0	0.0	2	0.1	2	0.1	3	0.2
25–34	6	0.3	4	0.2	2	0.1	2	0.1	2	0.1
35–44	10	0.5	11	0.7	10	0.6	12	0.8	4	0.3
45–54	21	1.0	19	1.2	21	1.4	26	1.8	23	1.4
55–64	66	3.3	56	3.5	54	3.5	61	4.1	54	3.4
65–74	266	13.3	182	11.3	192	12.5	178	12.1	201	12.6
75–84	651	32.5	499	31.1	523	33.9	483	32.7	516	32.3
85+	978	48.8	825	51.4	729	47.3	705	47.8	790	49.4
TOTAL	2,006		1,605		1,542		1,476		1,600	

* When pneumonia or influenza is classified as underlying cause of death.
** Seasonal frequencies; months November through March.

What occurred locally during 2003-04 was unusual and demonstrates the discord between the public's reaction to influenza versus actual impact of the season. The number of positive viral isolates reported from sentinel sites in Los Angeles County was substantially greater than any of the previous four seasons. In fact, the demand for testing was so overwhelming that during the peak of activity (week 51) our primary contributing laboratory suspended testing due to a depletion of supplies. However, the rates of influenza-related deaths and hospitalizations tell a different picture. As mentioned, there were fewer influenza and pneumonia deaths in 2003-04 as compared to 1999-00 (Table 1). Also, Kaiser Permanente data aggregated from Southern California show the 2003–04 season resulted in fewer influenza-related hospitalizations than the comparable 1999–00 season. The discrepancy in these findings can be explained by anecdotal accounts describing last season's surge in patient visits as consisting of the "worried well"—clinics were overwhelmed by individuals who were especially anxious, but not necessarily especially ill. In other seasons, when influenza did not garner the intense media attention that it did during late-2003, these individuals likely would have not have sought medical treatment.

Our county mortality data can also correct the prevailing misperception that the 2003–04 season caused unprecedented numbers of influenza-related pediatric deaths (Table 1). Comparing the last five seasons, there were actually fewer pediatric deaths during 2003–04 than the previous four seasons. And more importantly, pediatric cases consistently contribute only slightly to the overall pneumonia and influenza mortality rate; across the past five years, more than 90% of all deaths resulting from pneumonia and influenza during influenza season were among residents 65 years and older. This finding further demonstrates the overwhelming need to vaccinate the elderly in our county.

Continued on page 8

Adult Immunization Recommendations

Vaccine-preventable diseases, including influenza and pneumococcal disease, kill over 60,000 adults per year. Although vaccines are among the most effective public health measures available to prevent disease, many health care professionals fail to adequately immunize their patients. This year's National Adult Immunization Awareness Week is September 26th to October 2nd, 2004. Therefore, we want to remind all providers that every visit to a health care professional provides an opportunity to assess the patient's immunization needs and to bring their vaccinations up-to-date.

You may use the attached "Summary of Recommendations of Adult Immunization" (July 2004), from the Immunization Action Coalition (IAC) which was adapted from the recommendations of the Advisory Committee on Immunization Practices (ACIP), to review the immunization needs of your patients during each office visit. The IAC is a nonprofit organization that works to increase immunization rates and prevent disease by creating and distributing educational materials for health professionals and the public.

For more information on adult immunization, contact the Los Angeles County Immunization Program at (213) 351-7800 or visit the Immunization Program website at www.lapublichealth.org/ip. For more information concerning the influenza vaccination recommendations, refer to the article in this issue of The Public's Health.

Halloween Safety Tips

Halloween is an exciting holiday for children. Help ensure they have a safe holiday and review these safety tips from the Los Angeles County Department of Health Services.

Trick-or-treat preparations

All Ages

Use costumes that are bright and reflective. Make sure that shoes fit well and costumes are short enough to prevent tripping, entanglement or contact with flames. Costume materials must be flame proof.
Consider adding reflective tape or striping to costumes and Trick-or-Treat bags for better visibility.
Do not use simulated knives, guns, or swords that look real. If props are used, make sure they ***do not look real***, and are soft and flexible to prevent injury.
When shopping for costumes, wigs and accessories, purchase only those with a label clearly indicating they are flame resistant.
All children and adults should carry flashlights with fresh batteries. Use only battery powered lanterns or chemical lightsticks in place of candles for costumes and decorations.

Ages 13 and older

Plan and review an acceptable route with your children. Choose a familiar neighborhood and visit homes that have well lit driveways and paths.
Teach children to dial 9-1-1 for emergencies or if they are lost. Remember 9-1-1 can be dialed FREE at any payphone.
Have all children wear a wristwatch and carry coins for non-emergency phone calls.
Instruct your child to never enter a home or an apartment building unless accompanied by a familiar adult.
Because masks can limit or block vision, consider using non-toxic makeup and decorative hats as safer alternatives.
Agree on a specific time when they are to return home.
Openly discuss appropriate and inappropriate behavior at Halloween time.

Ages 12 and younger

Children 12 years of age and younger must be accompanied by an adult when going door to door.
Secure emergency identification (name, address, phone number) discreetly on Halloween clothing or on a bracelet in case a child gets separated from the adult.
Remember to review with your children the "Stop-Drop-Roll" drill, should their clothes ever catch on fire.

Safe Alternatives

Community centers, shopping malls and houses of worship may have organized festivities.
Share the fun by arranging a visit to a retirement home or senior center.
Create an alliance with college fraternities, sororities or service clubs for children's face painting or a carnival.

Home Decorating

Small children should never carve pumpkins. Children can draw a face with markers while parents finish cutting. Under a parents' supervision, children, ages 5 to 10, can use pumpkin cutters equipped with safety bars.
Votive candles are safest for candle-lit pumpkins.
Lighted pumpkins should be placed on a sturdy table, away from curtains and other flammable objects, and should never be left unattended.
To keep your home safe for visiting trick-or-treaters, remove anything a child could trip over such as garden hoses, toys, bikes and lawn decorations.

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Home Decorating, Continued

Check outdoor lights and replace burned-out bulbs.
Wet leaves should be swept from sidewalks and steps.
Consider fire safety when decorating. Do not overload electrical outlets with holiday lights or special effects.
Keep Jack O' Lanterns and hot electric decorations away from drapes, decorations, flammable materials or areas where children will be standing or walking.

Before going out: Halloween Eve

A good meal before parties and trick-or-treating will discourage youngsters from filling up on Halloween treats.
Consider purchasing non-food treats for those who visit your home.
Remind children and escorts (an adult or 13 years of age or older) to wait until you have sorted and checked their treats before they eat them.
Remind children and escorts to never run between parked vehicles and cross streets at crosswalks.
Remind children and escorts to not enter homes or apartments.
Again, review with your children and escorts the route and behavior which is acceptable to you. Remind them of the specific time they are to return home.
Confine, segregate or prepare household pets for an evening of frightful sights and sounds. Be sure that dogs and cats are wearing collars and proper identification tags. Consult your veterinarian for further advice.
Remind all household drivers to remain cautious and drive slowly throughout the community.
Adult partygoers should establish and reward a designated driver.

While Trick-or-Treating:

A parent or responsible adult should always accompany young children on their neighborhood rounds and remember to:

- Use a flashlight, children can see and can be seen by others.
- Stay in a group and communicate where they will be going.
- Only go to homes with a porch light on.
- Remain on well-lit streets and always use the sidewalk.
- If no sidewalk is available, walk at the farthest edge of the roadway facing traffic.
- Never cut across yards or use alleys.
- Never enter a stranger's home or car for a treat.
- Obey all traffic and pedestrian regulations.
- Always walk. Never run across a street.
- Only cross the street as a group in established crosswalks.
- Remove any mask or item that will limit eyesight before crossing a street, driveway or alley.
- Don't assume the right of way. It is difficult for Motorists to see Trick-or-Treaters. Just because one car stops, doesn't mean others will!
- Never consume unwrapped food items or open beverages even if offered.
- Law enforcement authorities should be notified immediately of any suspicious or unlawful activity.

After Trick-or-Treating

Wait until children are home to sort and check treats. Though tampering is rare, adults should closely examine all treats and throw away any spoiled, unwrapped or suspicious items. Remember, when in doubt~throw it out!
Try to portion treats for the days following Halloween.
Although sharing is encouraged, make sure items that can cause choking (such as hard candies), are given only to those of an appropriate age.

Have a safe and happy Halloween!

County of Los Angeles
Department of Health Services
Public Health

For more information on injury prevention call the Los Angeles County Department of Health Services, Injury & Violence Prevention Program at (213) 351-7888 or visit us online at www.lapublichealth.org

Influenza 2004-05: (from page 5)

Enhanced Pediatric Influenza Surveillance

In light of the reports of influenza-related pediatric deaths in Colorado in mid-November 2003, the CDC responded with a special surveillance project; doctors and hospitals were asked to report influenza-associated pediatric deaths as well as pediatric intensive care cases with confirmed influenza infection, particularly cases of encephalopathy or encephalitis. Across California, 124 severe influenza cases were reported throughout the season including 8 deaths. Of these, many of the cases (n=48, 39%) including 3 deaths, were reported from Los Angeles County.

Since this was the first time such a project was enacted, data from previous years are unavailable for comparison. Nonetheless, the findings provide some interesting information about severe pediatric influenza cases. Of note, about half of the California cases (n=67, 54%) and half of the Los Angeles County cases (n=24, 50%) fall into risk groups for which influenza vaccination is now recommended by the CDC (e.g., age 6 to 23 months or possessing a chronic medical condition such as cardiac, pulmonary or endocrine disease or immunocompromised status).

But more importantly, very few of these high-risk cases reported receiving influenza vaccination; only 12 (13%) of the high-risk California cases and 3 (13%) of the high-risk Los Angeles County cases reported influenza vaccination for the 2003–04 season. Thus the vast majority of pediatric cases in greatest need of influenza immunization were not vaccinated.

Immunization changes for 2004-05

As expected, the vaccine composition for the 2004–05 season has been adapted to include the novel Fujian strain that was prevalent during 2003–04. Also, because of heightened concern surrounding pediatric influenza cases, the National Immunization Program of the CDC implemented two important changes for the 2004–05 season. First, recommendations for vaccination have been expanded to protect more people from influenza, including infants and children 6 to 23 months of age, as well as household contacts and out-of-home caregivers of children 0 to 23 months of age; the goal is to prevent these contacts from infecting young children with influenza. Second, funding has been allotted to stockpile vaccine to ensure better access to vaccination for children, 18 years and younger, eligible for the Vaccine for Children program, an estimated 54% of U.S. children.

Recommendations

*Influenza Vaccination Recommendations 2004-2005**

CDC urges influenza vaccination for:

- Persons 65 years of age and older;
- Residents (of any age) of nursing homes and other chronic care facilities;
- Anyone with chronic disorders of the pulmonary or cardiovascular systems, including asthma;
- Anyone that required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression including those with HIV;
- Children and adolescents (aged 6 months-18 years) receiving long-term aspirin therapy because of the risk of contracting Reye syndrome;
- Women who will be pregnant during influenza season; and
- Children aged 6-23 months.

CDC also recommends influenza vaccination for:

- Persons aged 50-64 years;
- Anyone who might transmit influenza to those at increased risk of complications such as:
  - Physicians, nurses, and other personnel in both hospital and outpatient-care settings, including medical emergency response workers;
  - Employees of nursing homes and chronic-care facilities who have contact with patients or residents;
  - Employees of assisted living and other residences for persons in groups at high-risk;
  - Persons who provide home care to persons in groups at high-risk; and
  - Household contacts (including children) of persons in groups at high risk.

* **Adapted from CDC. Prevention and control of influenza:**
Recommendations of the Advisory Committee on Immunization Practices. MMWR 2004; 53:1-40. Available at: www.cdc.gov/mmwr/pdf/rr/rr53e430.pdf

Summary of Recommendations for Adult Immunization

Adapted from the recommendations of the Advisory Committee on Immunization Practices (ACIP)* by the Immunization Action Coalition, July 2004

Vaccine name and route	For whom it is recommended	Schedule for routine and "catch-up" administration	Precautions and contraindications (mild illness is not a contraindication)
Influenza Trivalent inactivated influenza vaccine (TIV) *Give IM* Live attenuated influenza vaccine (LAIV) *Give intranasally*	• All adults who are 50yrs of age or older. • People 6m–50yrs of age with medical problems (e.g., heart disease, lung disease, diabetes, renal dysfunction, hemoglobinopathies, immunosuppression) and/or people living in chronic-care facilities. • People (≥6m of age) working or living with at-risk people. • Women who will be pregnant during the influenza season. • All health care workers and other persons who provide direct care to at-risk people. • Household contacts and out-of-home caregivers of children ages 0–23m. • Travelers at risk for complications of influenza who go to areas where influenza activity exists or who may be among people from areas of the world where there is current influenza activity (e.g., on organized tours). • Persons who provide essential community services. • Students or other persons in institutional settings (e.g., those who reside in dormitories). • Anyone wishing to reduce the likelihood of becoming ill with influenza. **Special Notes on the use of influenza vaccines** • Inactivated influenza vaccine may be given to any person ≥6 months of age for whom the vaccine is not contraindicated. Live attenuated influenza vaccine may be given to healthy, non-pregnant persons 5–49 years of age for whom the vaccine is not contraindicated. • Use of inactivated influenza vaccine is preferred for persons in close contact with severely immunosuppressed persons during periods when the immunocompromised person requires a protective environment (e.g., persons with bone marrow transplants).	• Given every year. • October through November is the *optimal* time to receive annual influenza vaccination to maximize protection. • Influenza vaccine may be given at any time during the influenza season (typically December through March) or at other times when the risk of influenza exists. • May give with all other vaccines.	• Previous anaphylactic reaction to this vaccine, to any of its components, or to eggs. • Moderate or severe acute illness. • Do not give live attenuated influenza vaccine to persons ≥50 years of age, pregnant women, or to persons who have: asthma, reactive airway disease or other chronic disorder of the pulmonary or cardiovascular systems; an underlying medical condition, including metabolic diseases such as diabetes, renal dysfunction, and hemoglobinopathies; a known or suspected immune deficiency disease or who are receiving immunosuppressive therapy; a history of Guillain-Barré syndrome. • See Special Notes in columns 2–3 regarding who may not receive LAIV.
Pneumococcal polysaccharide (PPV23) *Give IM or SC*	• Adults who are 65yrs of age or older. • People 2–64yrs of age who have chronic illness or other risk factors, including chronic cardiac or pulmonary diseases, chronic liver disease, alcoholism, diabetes mellitus, CSF leaks, candidate for or recipient of cochlear implant, as well as people living in special environments or social settings (including Alaska Natives and certain American Indian populations). Those at highest risk of fatal pneumococcal infection are people with anatomic asplenia, functional asplenia, or sickle cell disease; immunocompromised persons including those with HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, or nephrotic syndrome; persons receiving immunosuppressive chemotherapy (including corticosteroids); and those who received an organ or bone marrow transplant. Pregnant women with high-risk conditions should be vaccinated if not done previously.	• Routinely given as a one-time dose; administer if previous vaccination history is unknown. • One-time revaccination is recommended 5yrs later for people at highest risk of fatal pneumococcal infection or rapid antibody loss (e.g., renal disease) and for people ≥65yrs of age if the 1st dose was given prior to age 65 and ≥5yrs have elapsed since previous dose. • May give with all other vaccines.	• Previous anaphylactic reaction to this vaccine or to any of its components. • Moderate or severe acute illness. **Note:** Pregnancy and breastfeeding are not contraindications to the use of this vaccine.
Hepatitis B (Hep B) *Give IM* Brands may be used interchangeably.	• All adolescents. • High-risk adults, including household contacts and sex partners of HBsAg-positive persons; users of illicit injectable drugs; heterosexuals with more than one sex partner in 6 months; men who have sex with men; people with recently diagnosed STDs; patients receiving hemodialysis and patients with renal disease that may result in dialysis; recipients of certain blood products; health care workers and public safety workers who are exposed to blood; clients and staff of institutions for the developmentally disabled; inmates of long-term correctional facilities; and certain international travelers. **Note:** Prior serologic testing may be recommended depending on the specific level of risk and/or likelihood of previous exposure. **Note:** In 1997, the NIH Consensus Development Conference, a panel of national experts, recommended that hepatitis B vaccination be given to all anti-HCV positive persons. **Ed. note:** Provide serologic screening for immigrants from endemic areas. When HBsAg-positive persons are identified, offer appropriate disease management. In addition, screen their sex partners and household members and, if found susceptible, vaccinate.	• Three doses are needed on a 0, 1, 6m schedule. • Alternative timing options for vaccination include 0, 2, 4m and 0, 1, 4m. • There must be 4wks between doses #1 and #2, and 8wks between doses #2 and #3. Overall there must be at least 16wks between doses #1 and #3. • **Schedule for those who have fallen behind:** If the series is delayed between doses, DO NOT start the series over. Continue from where you left off. • May give with all other vaccines. For Twinrix™ (hepatitis A and B combination vaccine [GSK]), three doses are needed on a 0, 1, 6m schedule.	• Previous anaphylactic reaction to this vaccine or to any of its components. • Moderate or severe acute illness. **Note:** Pregnancy and breastfeeding are not contraindications to the use of this vaccine.
Hepatitis A (Hep A) *Give IM* Brands may be used interchangeably.	• People who travel outside of the U.S. (except for Western Europe, New Zealand, Australia, Canada, and Japan). • People with chronic liver disease, including people with hepatitis C; people with hepatitis B who have chronic liver disease; illicit drug users; men who have sex with men; people with clotting-factor disorders; people who work with hepatitis A virus in experimental lab settings (not routine medical laboratories); and food handlers when health authorities or private employers determine vaccination to be cost effective. **Note:** Prevaccination testing is likely to be cost effective for persons >40yrs of age as well as for younger persons in certain groups with a high prevalence of hepatitis A virus infection.	• Two doses are needed. • The minimum interval between dose #1 and #2 is 6m. • If dose #2 is delayed, do not repeat dose #1. Just give dose #2. • May give with all other vaccines.	• Previous anaphylactic reaction to this vaccine or to any of its components. • Moderate or severe acute illness. • Safety during pregnancy has not been determined, so benefits must be weighed against potential risk. **Note:** Breastfeeding is not a contraindication to the use of this vaccine.

Summary of Recommendations for Adult Immunization (continued)

Vaccine name and route	For whom it is recommended	Schedule for routine and "catch-up" administration	Precautions and contraindications (mild illness is not a contraindication)
Td (Tetanus, diphtheria) *Give IM*	• All adolescents and adults. • After the primary series has been completed, a booster dose is recommended every 10yrs. Make sure your patients have received a primary series of 3 doses. • A booster dose as early as 5yrs later may be needed for the purpose of wound management, so consult ACIP recommendations.* • Use Td, not tetanus toxoid (TT), for all indications.	• Give booster dose every 10yrs after the primary series has been completed. • For those who are unvaccinated or behind, complete the primary series (spaced at 0, 1–2m, 6–12m intervals). Don't restart the series, no matter how long since the previous dose. • May give with all other vaccines.	• Previous anaphylactic or neurologic reaction to this vaccine or to any of its components. • Moderate or severe acute illness. **Note:** Pregnancy and breastfeeding are not contraindications to the use of this vaccine.
MMR (Measles, mumps, rubella) *Give SC*	• Adults born in 1957 or later who are ≥18yrs of age (including those born outside the U.S.) should receive at least one dose of MMR if there is no serologic proof of immunity or documentation of a dose given on or after the first birthday. • Adults in high-risk groups, such as health care workers, students entering colleges and other post–high school educational institutions, and international travelers, should receive a total of two doses. • Adults born before 1957 are usually considered immune but proof of immunity may be desirable for health care workers. • All women of childbearing age (i.e., adolescent girls and premenopausal adult women) who do not have acceptable evidence of rubella immunity or vaccination. • Special attention should be given to immunizing women born outside the United States in 1957 or later.	• One or two doses are needed. • If dose #2 is recommended, give it no sooner than 4wks after dose #1. • May give with all other vaccines. • If varicella vaccine and MMR are both needed and are not administered on the same day, space them at least 4wks apart. • If a pregnant woman is found to be rubella-susceptible, administer MMR postpartum.	• Previous anaphylactic reaction to this vaccine or to any of its components. • Pregnancy or possibility of pregnancy within 4 weeks (use contraception). • Persons immunocompromised because of cancer, leukemia, lymphoma, immunosuppressive drug therapy, including high-dose steroids or radiation therapy. **Note:** HIV positivity is NOT a contraindication to MMR except for those who are severely immunocompromised. • If blood, plasma, and/or immune globulin were given in past 11m, see ACIP statement *General Recommendations on Immunization** regarding time to wait before vaccinating. • Moderate or severe acute illness. **Note:** Breastfeeding is not a contraindication to the use of this vaccine. **Note:** MMR is not contraindicated if a tuberculin skin test (i.e., PPD) was recently applied. If PPD and MMR not given on same day, delay PPD for 4–6wks after MMR.
Varicella (Var) (Chickenpox) *Give SC*	All susceptible adults and adolescents should be vaccinated. It is especially important to ensure vaccination of the following groups: susceptible persons who have close contact with persons at high risk for serious complications (e.g., health care workers and family contacts of immunocompromised persons) and susceptible persons who are at high risk of exposure (e.g., teachers of young children, day care employees, residents and staff in institutional settings such as colleges and correctional institutions, military personnel, adolescents and adults living with children, non-pregnant women of childbearing age, and international travelers who do not have evidence of immunity). **Note:** People with reliable histories of chickenpox (such as self or parental report of disease) can be assumed to be immune. For adults who have no reliable history, serologic testing may be cost effective since most adults with a negative or uncertain history of varicella are immune.	• Two doses are needed. • Dose #2 is given 4–8wks after dose #1. • May give with all other vaccines. • If varicella vaccine and MMR are both needed and are not administered on the same day, space them at least 4wks apart. • If the second dose is delayed, do not repeat dose #1. Just give dose #2.	• Previous anaphylactic reaction to this vaccine or to any of its components. • Pregnancy or possibility of pregnancy within 4 weeks (use contraception). • Persons immunocompromised because of malignancies and primary or acquired cellular immunodeficiency including HIV/AIDS. (See *MMWR* 1999, Vol. 48, No. RR-6.) **Note:** For those on high-dose immunosuppressive therapy, consult ACIP recommendations regarding delay time.* • If blood, plasma, and/or immune globulin (IG or VZIG) were given in past 11m, see ACIP statement *General Recommendations on Immunization** regarding time to wait before vaccinating. • Moderate or severe acute illness. **Note:** Breastfeeding is not a contraindication to the use of this vaccine. **Note:** Manufacturer recommends that salicylates be avoided for 6wks after receiving varicella vaccine because of a theoretical risk of Reye's syndrome.
Polio (IPV) *Give IM or SC*	Not routinely recommended for persons 18yrs of age and older. **Note:** Adults living in the U.S. who never received or completed a primary series of polio vaccine need not be vaccinated unless they intend to travel to areas where exposure to wild-type virus is likely. Previously vaccinated adults can receive one booster dose if traveling to polio endemic areas.	• Refer to ACIP recommendations* regarding unique situations, schedules, and dosing information. • May give with all other vaccines.	• Previous anaphylactic or neurologic reaction to this vaccine or to any of its components. • Moderate or severe acute illness. **Note:** Pregnancy and breastfeeding are not contraindications to the use of this vaccine.
Meningococcal *Give SC*	Vaccinate people with risk factors. Discuss disease risk and vaccine availability with college students. Consult ACIP statement* on meningococcal disease (6/30/00) for details.		

* For specific ACIP immunization recommendations, refer to the statements, which are published in *MMWR*. To obtain a complete set of ACIP statements, call (800) 232-2522, or to access individual statements, visit CDC's website: www.cdc.gov/nip/publications/ACIP-list.htm or visit IAC's website: www.immunize.org/acip

This table is revised yearly because of the changing nature of U.S. immunization recommendations. Visit the Immunization Action Coalition's website at www.immunize.org/adultrules to make sure you have the most current version. We extend our thanks to William Atkinson, MD, MPH, from CDC's National Immunization Program, and Linda Moyer, RN, from the Division of Viral Hepatitis, at CDC's National Center for Infectious Diseases for their assistance. This table is published by the Immunization Action Coalition, 1573 Selby Avenue, St. Paul, MN 55104, (651) 647-9009. Email: admin@immunize.org

Local Pediatric Immunization Coverage Increases

The Los Angeles County Department of Health Services Immunization Program (IP) recently received an award for increasing childhood immunization coverage rates as measured by the National Immunization Survey (NIS) . Dr. A. Nelson El Amin, IP Medical Director accepted the award before a crowd of 2000 people attending the National Immunization Conference held in Nashville Tennessee during May.

The award was for an increase in immunization coverage rates among children 19-35 months of age living in Los Angeles County. The county rate increased from **71.3% to 82.4% for the 4:3:1:3:3 vaccine series** (4 doses of Diphtheria/Tetanus/Pertussis vaccine, 3 doses of Polio vaccine[1], 1 dose of Measles vaccine, 3 doses of *Haemophilus influenzae* type b (Hib) vaccine, and 3 doses of Hepatitis B vaccine). The improved coverage levels are the result of the efforts of many individuals, especially the healthcare providers that serve the infants and children in the county. Such an increase in coverage levels is unprecedented in the history of Los Angeles County. Although the current coverage rate is above the Healthy People 2010 goal of 80%, continued attention is needed to maintain and increase rates, as the NIS survey coverage rates are estimated averages based on a small sample of children 19-35 months of age in the county.

IP supplies publicly funded vaccines to the county health department and more than 200 non-profit clinics and serves several other functions including:

- serves as the primary data collection and analysis unit for immunization coverage levels
- provides trainings to both professional and lay individuals
- conducts outreach to populations at-risk for under-immunization
- promotes timely immunizations through media outreach campaigns
- responsible for the surveillance of childhood vaccine preventable diseases.

IP recently began a new project – Immunization Practices Improvement Initiative (IPII) – a case managed, quality improvement process consisting of assessment of immunization coverage rates, feedback of those rates and other pertinent data, incentives for improvement, and exchange of best practices. IPII is targeted to immunization providers and utilizes case management to ensure that providers receive regular training, follow-up and feedback. The case management team includes, nurses, health educators, researchers, vaccine management specialists, and outreach specialists, thus allowing IP to work with the entire provider office system.

IP has also begun the process of implementing a countywide immunization registry, known as LINK (Los Angeles Immunization Network), to minimize 'missed-opportunities' for vaccination as well as un-needed vaccinations when the parent or provider's records are not up-to-date or incomplete.

For further information about the LINK, IPII, or the Immunization Program, visit www.lapublichealth.org/ip, or call 213-351-7800.

Reference

1. The NIS provides estimates of vaccination coverage levels in children ages 19-35 months through a random-digit-dial method. Each phone number is randomly generated and then linked to geographic areas based upon area codes then prefixes. If the randomly selected household has a child aged 19-35 months, immunization histories are collected for that child. Demographic data is also collected. Additionally, permission to contact all of the medical providers that have vaccinated the child is then obtained. The NIS then contacts the medical providers to confirm information and collect any missing data to formulate a complete record. Immunization coverage rates are based on the collected data from children with completed interviews and adequate provider data.

As Halloween approaches, children may have thoughts of jack-o'-lanterns and haunted houses. However, adults should remember this thrilling night can also be one of the most dangerous. As children embark on "Trick-or-Treating" the risk of unintentional injury shadows them with pedestrian injuries,burns, and falls. Children are likely to be distracted by the excitement and forget street safety precautions. The risks children face on Halloween can be prevented if parents discuss safety precautions with their children and follow **the Halloween Safety tips enclosed.**

This Issue . . .

Pull-out poster for Respiratory Hygiene Awareness Campaign and Halloween Safety Tips Inside

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

County of Los Angeles
Department of Health Services
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

Selected Reportable Diseases (Cases)[1] - April 2004

Disease	THIS PERIOD April 2004	SAME PERIOD LAST YEAR April 2003	YEAR to date April 2004	YEAR to date April 2003	YEAR END TOTALS 2003	YEAR END TOTALS 2002	YEAR END TOTALS 2001
AIDS[1]	198	260	733	731	2,590	1,719	1,354
Amebiasis	3	14	21	38	121	102	139
Campylobacteriosis	53	77	277	311	1,093	1,067	1,141
Chlamydial Infections	3,133	3,074	12,696	12,415	36,585	34,680	31,658
Encephalitis	7	3	19	17	41	61	41
Gonorrhea	793	635	3,044	2,505	8,014	7,540	7,468
Hepatitis Type A	38	24	123	127	376	438	542
Hepatitis Type B, Acute	3	6	23	24	56	29	44
Hepatitis Type C, Acute	0	0	3	0	0	3	1
Measles	0	0	0	0	0	0	8
Meningitis, viral/aseptic	44	79	137	177	899	466	530
Meningococcal Infections	2	2	15	15	34	46	58
Mumps	1	4	1	6	10	16	17
Non-gonococcal Urethritis (NGU)	124	129	512	491	1,393	1,256	1,343
Pertussis	12	20	52	70	128	170	103
Rubella	0	0	0	0	0	0	0
Salmonellosis	108	70	344	283	996	956	1,006
Shigellosis	18	55	111	321	671	974	684
Syphilis, primary & secondary	38	34	142	147	448	355	181
Syphilis, early latent (<1 yr.)	37	40	127	137	377	348	191
Tuberculosis	56	86	171	216	949	1,021	1,046
Typhoid fever, Acute	2	0	3	5	16	33	17

1. Case totals are provisional and may vary following periodic updates of the database.

Data provided by DHS Public Health programs: Acute Communicable Disease Control, HIV/Epidemiology, Sexually Transmitted Diseases, and Tuberculosis Control.