

NOT FOR PUBLICATION

CHSC(VI)(1977)

THIRD MEETING

CENTRAL HEALTH SERVICES COUNCIL  
 SCOTTISH HEALTH SERVICE PLANNING COUNCIL  
 JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minutes of meeting held on 10 October 1977

The following members were present:-

Professor Sir Charles Stuart-Harris ( Chairman)	
Dr F S W Brimblecombe	Professor H P Lambert
Professor G W A Dick	Dr T M Pollock
Professor J A Dudgeon	Dr D Reid
Professor G Edsall	Dr G C Schild
Professor R W Gilliatt	Dr R G Small
Professor N R Grist	Dr J W G Smith
Dr H R Jolly	Dr V H Springett
Professor J Knowelden	Sir Robert Williams
Mr J M Foster (Secretary)	Dr W O Williams

Also present:-

Dr N J B Evans	} Department of Health and Social Security
Dr W N Dunnet	
Dr J A Holgate	
Dr R W Andrews	
Dr A Smithies	
Dr M Smith	
Miss D Harding	
Mr R P Pole	
Mr W J Lester	
Mrs J Atkinson	
Miss M S Moran	

Professor D L Miller	-	Middlesex Hospital Medical School
Dr R Logan	-	Department of Health and Social Services, Northern Ireland
Dr W C D Lovett	-	Welsh Office
Dr W M Prentice	-	Scottish Home and Health Department
Brigadier J C Crook	-	Ministry of Defence

1. APOLOGIES FOR ABSENCE

Apologies were received from Dr M F H Bush, Sir David Evans, Dr J S Noble and Dr G I Watson.

The Chairman welcomed Dr R G Small on his appointment to the Committee.

2. MINUTES OF THE MEETING HELD ON 3 MAY 1977

The minutes of the last meeting were certified as correct and signed by the Chairman.

3. MATTERS ARISING

Warnings to patients - The Chairman referred to [redacted] letter to him of 1 September 1977 which had been laid before the Committee. [redacted] explained that whereas the Committee's advice on contra-indications to vaccination had been issued to doctors and nurses, the guide lines on warnings to patients had been omitted pending discussion with the medical defence organisations. The Department wished the Joint Committee to know that this matter was nevertheless being pursued.

[redacted] indicated his anxiety lest doctors and nurses were not receiving necessary advice, particularly in view of the volume of enquiries from parents. Criticisms were expressed by various members, with which the Chairman agreed, of the Health Education Council leaflet, which had omitted a good deal of information provided in the draft prepared by the Committee.

Item 4 - [redacted] said that there had been very little criticism of the Report on Whooping Cough Vaccination which had been published in June and widely distributed. [redacted] thanked the Chairman and members, on behalf of the Secretary of State, for their work on the Report, especially as it was carried out in so short a time. Already there was evidence that the fall in acceptance rates for whooping cough vaccination had been halted. [redacted] said that the Secretary of State proposed to launch a campaign on 28 October to improve the uptake of vaccination.

Several members spoke of the apparent failure to distribute the Report to junior hospital doctors. [redacted] explained the Department's procedure for such distributions: area medical officers were responsible for ensuring that publications reached relevant hospital medical staff but enquiries would be made by the Department with a view to remedying the situation.

Item 5 - [REDACTED] introduced a draft CMO letter on influenza, which had been prepared in the light of members' comments. This was agreed after minor adjustments.

[REDACTED] confirmed that the current influenza situation was very quiet. [REDACTED] suggested that the vaccine should be considered for old people generally and the [REDACTED] indicated that this would be taken up with the Influenza Advisory Group at the appropriate time.

Item 7 - A note on progress by the Department was laid before the Committee. [REDACTED] spoke of the CHSC's concern over the uptake of rubella vaccination particularly by women in the childbearing age-group and referred to a meeting of AMOs and others organised by the Faculty of Community Medicine. He felt that many authorities were not really putting enough effort into implementing the programme. A full report on the Devon Pilot scheme was expected in the Spring.

[REDACTED] said that the Devon Pilot scheme had proved encouraging in that 1460 women had had blood samples taken for rubella antibody testing in 3 health district family planning clinics; but follow-up had revealed that only 50% of a sample of susceptible women had received vaccination. Ways of improving the follow up of these susceptible women were being explored. 250 of these, as yet unvaccinated, were currently being sought. A research team was visiting the area.

Mention was made of difficulties which some AMOs alleged when PHLS laboratories were asked to carry out serological tests. [REDACTED] was not aware of any shortage of PHLS facilities and said that he would like to hear of any difficulties. [REDACTED] undertook to send him details of the AMOs in question.

[REDACTED] referred to the Health Education Council's leaflet on rubella vaccination which was being revised. [REDACTED] said that the existing leaflet was inaccurate. It was agreed that members should be given the opportunity to comment on the revised leaflet at draft stage.

4. REPORT ON THE ORAL POLIOMYELITIS VACCINE SUPPLY SITUATION (CHSC(VI)(77)20)

[REDACTED] outlined the precarious position regarding supplies of poliovaccine. He asked the Committee to bear in mind the increased incidence of paralytic cases this year and the report of the Institute of Medicine of the American

Academy. This advised the use of oral poliovaccine for basic immunisation in childhood and inactivated poliovaccine for basic immunisation of adults.

The Committee agreed that, with the present levels of acceptance, trivalent oral poliovaccine was preferred for basic immunisation of children and for the booster dose at school entry. Inactivated poliovaccine, if available, could be used for reinforcing doses at school leaving age and for adults receiving basic immunisation.

Where a sporadic case of poliomyelitis occurred it was agreed that the issue of oral poliovaccine should be limited to persons in the community with whom the case had been in close proximity; and that vaccination should be directed particularly to children in the same class or school or living in the same road or community as the patient concerned.

The priorities for the use of oral trivalent poliomyelitis vaccine were thus for:-

1. Local epidemiological control around a case or cases of poliomyelitis, restricted to children and adolescents with whom the case was in possible contact;
2. Basic immunisation of children;
3. Booster doses for children at school entry.

The use of the export formula vaccine (in which the TCID<sub>50</sub> of Types I, II and III had a titre of  $10^{5.3}$ ) was accepted for use in epidemiological control of a case or cases of poliomyelitis and one dose of this vaccine could be regarded as one of the doses of the basic course of immunisation.

Monovalent vaccine was accepted for epidemiological control in the event of a case or cases of poliomyelitis, if possible a monovalent vaccine of the same type as that isolated from the index case should be used but if this was not possible monovalent Type II vaccine which provoked some cross immunity should be given.

It was agreed that it was highly desirable to limit wastage of vaccine.

The use of multi-dose containers was known to be one of the causes of wastage and it was noted that the problem was being investigated.

The use of a trivalent vaccine prepared from a mixture of batches of monovalent bulk derived either in monkey kidney cells or human diploid cells was considered to be quite acceptable although it was considered that small clinical trials of this mixed vaccine would probably be advisable. Monovalent vaccines of a different type for each dose of the basic course (ie 1st dose Type I 2nd dose Type III 3rd dose Type II) was considered to provide good antibody response.

██████████ questioned whether vaccine-associated polio cases in the USA, when oral poliovaccine was first introduced, were possibly due to the method of giving the three types of oral vaccine. It was agreed that this method should not be recommended but could be reconsidered according to the outcome of the supply situation.

It was agreed that inactivated poliovaccine was acceptable (though not fully satisfactory) as an alternative to oral poliomyelitis vaccine for basic immunisation if difficulties in the supply of oral poliovaccine persisted.

██████████ said that the situation would be reviewed at the next meeting of the Committee.

5. REVISED SCHEDULES OF VACCINATION AND IMMUNISATION AS AGREED BY THE WORKING GROUP (CHSC(VI)(77)21)

██████████ proposed that the table of the schedule should, as in the covering CMO letter, emphasise positively that the first dose of triple antigen, together with oral poliovaccine should begin "at three months of age". ██████████ who said that confusion had resulted from the wording of CMO(77)7, suggested that qualifying the advice with the word 'may' would give greater flexibility to those who had already established satisfactory vaccination programmes starting at a later age. It was agreed by members of the Committee, ██████████ dissenting, that positive advice to start the programme at three months should be given.

██████████ that omission of the word "oral" in paragraph 2 of the Additional Notes on reinforcing doses would leave it optional to use inactivated poliovaccine which might promote an improved antibody response. This was agreed.

The recommendation by the Working Group of two schedules of vaccination was discussed. ██████████ and ██████████ thought such a recommendation might damage the vaccination programme. ██████████ reported that doubts had been expressed to him over the adjustment of the schedules. It was agreed that a single schedule for triple antigen or Diph/tet and oral polio should be recommended, starting at three months of age with a 6-8 week gap between the 1st and 2nd dose and a 4-6 month interval between the 2nd and 3rd dose. ██████████ proposed and it was agreed that reference should be made in the notes to an alternative schedule for triple and oral polio at 3, 4 and 5 months of age, with a booster at 18 months in the event of whooping cough epidemics.

6. (a) REPORT FROM COMMITTEE ON REVIEW OF MEDICINES ABOUT BCG VACCINE  
(CHSC (VI)(77)22)

At the Chairman's invitation [redacted] introduced a paper about the BCG vaccine recently introduced by Glaxo and asked for the Committee's views on the increase in reactions to BCG vaccine and their advice on the appropriate method of use.

[redacted] said that there were four reasons for reactions: use of Tine Test (which did not always indicate the state of immunity correctly), the viable count, depth of injection (if a needle was used) and use of the jet injector: all of these gave cause for concern. He strongly advocated that the use of the jet injector should be discontinued unless in very experienced hands.

It was agreed that only vaccine with a lower viable count should be recommended.

[redacted] suggested that a note about technique of BCG vaccination should be inserted in the draft revised guidance to doctors or "Immunisation against Infectious Disease."

(b) LETTER FROM MRC COMMITTEE ON DEVELOPMENT OF VACCINES (CHSC(VI)(77)23)

A letter of 15 September from the Secretary of the MRC Committee on Development of Vaccines drew attention to the problem discussed at (a) above. This was noted.

7. REPORT BY THE AD HOC GROUP TO CONSIDER THE USE OF PERTUSSIS VACCINE AND PROPHYLACTIC ANTIBIOTICS

[redacted] reported on the recommendations made by an ad hoc group who had met on 8 September to consider the use of pertussis vaccine and prophylactic antibiotics.

The group did not recommend the use of monovalent pertussis vaccine for children under the age of 3 months. They did recommend that this vaccine should be available for use in children over 3 months of age who had omitted pertussis in earlier vaccinations.

The group had found that evidence for the efficacy of antibiotics in the prophylaxis of whooping cough, either by suppressing the infectivity of the index case or by treating contacts of a case, was not sufficient to recommend their use. It was recommended that such trials of prophylactic antibiotics should be undertaken.

██████████ said that the Royal College of General Practitioners were at present considering trials. Some alarm was expressed at a proposal to circularise 8,000 general practitioners asking for their participation in the use of antibiotics. ██████████ agreed to write to the College expressing the Committee's view that it was essential that a controlled trial was undertaken.

██████████ agreed to prepare a written report of the ad hoc group meeting with the recommendations for trials of antibiotic prophylaxis which would then be put to the Chief Scientist.

8. SMALLPOX VACCINE (CHSC(VI)(77)24)

██████████ introduced the paper.

The Committee agreed that frozen dried vaccine could now replace glycerolated vaccine for use in the UK.

The Committee did not consider it of importance to review the use of smallpox vaccine until WHO had announced world eradication of the disease.

██████████ drew attention to the number of countries who required evidence of smallpox vaccination for entry and thought that WHO should be asked to review this.

9. (a) DIPHTHERIA VACCINES - PAPER FROM COMMITTEE ON REVIEW OF MEDICINES (CHSC(VI)(77)25)

██████████ requested the advice of the Committee on the necessity to continue the licensing of diphtheria TAF vaccine which contained horse serum and was likely to provoke reactions. It was agreed that there was no longer a need for this vaccine. An adsorbed vaccine with a low Lf would probably be satisfactory for adult immunisation.

██████████ wished to draw the Committee's attention to the inconsistencies between the manufacturers' literature, schedules of vaccination and the schedules recommended by JCVI. It was agreed that the Committee on Review of Medicines' attention should be drawn to the need to bring them into line.

(b) SUSCEPTIBILITY TO DIPHTHERIA (CHSC(VI)(77)26) - PAPER BY DR J W G SMITH

██████████ introduced the paper at the invitation of ██████████. It reinforced the suspicion that a certain percentage of the population was susceptible to diphtheria and that efforts were needed to increase diphtheria immunisation. The paper would shortly be published.

10. PROGRESS REPORT ON THE NATIONAL ENCEPHALOPATHY STUDY

██████████ said that the number of cases notified in the first year ending June 1977 was 387 and this was about the number expected.

Of these, 238 satisfied the criteria laid down for diagnosis as encephalopathy. 168 of these children recovered in two weeks, 102 recovered but with residual neurological signs. These would now be followed up for one year. The response from paediatricians was most encouraging and showed a response of about 80 per cent but it was sometimes difficult to obtain accurate immunisation histories.

11. PROPOSED PHLS STUDIES

- (a) Reactions to DT as compared with DTP vaccine ) (CHSC(VI)(77)27)
- (b) Current efficacy of whooping cough vaccination )

The papers were introduced by ██████████. The Committee supported the proposed investigations.

12. ANY OTHER BUSINESS

There was none.

13. DATE OF NEXT MEETING

No date was arranged.