NEW VACCINE ORDERING

For the first time, the Centers for Disease Control and Prevention (CDC) is implementing a national, centralized approach for vaccine distribution. Using a national, centralized distribution system will save time, ensure that vaccines arrive safely, enable the direct delivery of vaccines to providers and allow CDC to respond more quickly to public health crises. On September 11, 2006, CDC selected McKesson Specialty as the national vaccine distribution vendor. Specific information about McKesson can be found at www.mckessonspeciality.com

What this means for Connecticut

Beginning on June 11, 2007, the Connecticut Immunization Program is scheduled to switch to McKesson. In May, you will be given some additional vaccines, above the usual 2.5 months limits. This will cushion supplies to get you through the start up with McKesson. In addition to the switch in distributors, CDC is also requiring that states move to a Tiered Ordering Frequency Schedule (TOF). Tiered Ordering frequency is a provider ordering schedule that establishes the lowest total cost of distribution, by identifying the number of orders providers should place each year. The goal of TOF is to balance shipping costs with inventory & spoilage costs. Under TOF, providers will only be able to order at certain times of the year: high volume users will continue to order every month, medium volume users will move to every other month and low volume users will order on a quarterly schedule.

If you order vaccine through the state Immunization Program, you should already have been notified about the change. Contact the Immunization Program at 860-509-7929, if you have any questions.

ACIP

Minutes from the February 2007 ACIP meeting were not available at publication time. However, slide presentations from the meeting are available at:


April 21-28, 2007
National Infant Immunization Week (NIIW)
At A Glance

National Infant Immunization Week (NIIW) is an annual observance to promote the benefits of immunizations and to focus on the importance of immunizing infants against vaccine-preventable diseases by age two. For a list of events planned in CT, see insert of this edition of IAP on Time.
HPV Vaccine Target Groups and Benefits: Cervical Cancer Epidemiology in Connecticut, 1994–2003 (adapted from CT Epidemiologist Vol. 27 No. 2 Feb 2007)
Reported by: J Sosa MD, J Hadler MD, MPH, Epidemiology and Emerging Infections Program, Connecticut Department of Public Health.

In June 2006, a vaccine was approved for protection against four types of Human Papillomavirus (HPV). The vaccine approval was reported in the Fall 2006 (Vol. 10 No. 1) IAP on Time.

To determine the potential benefits of HPV vaccine and identify target groups for vaccination, the CT Department of Public Health conducted a descriptive epidemiological analysis of the most recent 10 years of cervical cancer data from the Connecticut Tumor Registry. Only data on cervical cancer, not carcinoma in situ, was included in the analysis. For overall and late-stage disease, incidence rates and relative rates were analyzed by age, race, ethnicity and urban residence (residence in one of the five towns with >100,000 people). Incidence rates were calculated using census data and intercensus estimates.

A total of 1467 cases of malignant cervical cancer were diagnosed during 1994-2003 in Connecticut residents. Median age was 50 years (range: 18-104 years). Late-stage diagnoses accounted for 16% of all cases. At the time of this analysis, just over 1/3 of the patients in the database had died and at least 44% had a cause of death attributable to their cervical cancer diagnosis. An average of 147 cases were reported each year with an overall incidence rate of 8.4 cases per 100,000 population (Figure 1.)

Figure 1. Cervical Cancer Reports and Annual Incidence Rates, CT, 1994-2003

Overall, persons of white race accounted for 84.5% of all cases, while persons of black race accounted for 12.5% of all cases. Cases described as being of Hispanic ethnicity increased from 7.1% in 1994 to 18.6% in 2003 (p<0.01). Overall incidence rates were higher for persons of Hispanic ethnicity, of black race, and for urban residents compared to the overall rate (10.0, 11.3 and 12.1/100,000 respectively).

Incidence rates for these three groups were analyzed for the latter five years of data (1999–2003) and cases were divided by those younger than 40 years and those 40

(Continued on page 4)
VACCINE SAFETY

Can you imagine having to say “I’m sorry Mrs. Johnson, you’ll have to come back so I can give little Danny another shot. The one I gave today was expired.”

Protect your patients, your practice, and your resources. Don’t let your vaccines expire.

Organization is the best way to prevent vaccines from meeting their expiration dates.

⇒ Order only what you’ll use. Stockpiling vaccines leads to waste.
⇒ Store vaccines in an orderly fashion, separated by their antigen type(s).
⇒ Place short-dated vaccines in front of longer-dated vaccines, to be used first.
⇒ Physically inventory and inspect expiration dates for each vaccine, every month.
⇒ Remove expired vaccines from cold storage to avoid inadvertent use.

Notes:
♦ Expired vaccine should be returned to the Immunization Program with a completed vaccine return form.
♦ If you notice during your monthly inventory that vaccines will be expiring in 2-3 months, move them to another VFC practice that will be able to use the vaccines before they spoil. (Copy CT DPH on the transfer form.)
♦ If you need to order vaccines but know that you will not use a whole box, call a neighboring VFC practice and share a box. (Copy CT DPH on the transfer form)

If you need assistance finding a home for your expiring vaccines, call the CT Immunization Program and ask your Field Epidemiologist for assistance.

LEGISLATIVE SESSION 2007

The current Connecticut state legislative session has a number of proposed bills with implications for immunizations. Below are bill numbers that have the potential to effect immunizations statewide.

To follow the progress of each bill, go to http://www.cga.ct. Insert the bill number in the box <number>, at the top of the page.

HPV VACCINE

SB 86: AN ACT ESTABLISHING STANDARDS FOR EARLY IMMUNIZATION AGAINST HUMAN PAPILLOMA VIRUS.

HB 5485: AN ACT CONCERNING HUSKY PLAN, PART A AND PART B COVERAGE FOR THE HUMAN PAPILLOMA VIRUS VACCINE.

HB 6085: AN ACT CONCERNING AN APPROPRIATION FOR INCREASING AWARENESS ABOUT HUMAN PAPILLOMA VIRUS AND CERVICAL CANCER.

HB 6977: AN ACT CONCERNING PREVENTION STRATEGIES FOR DISEASES CAUSED BY HUMAN PAPILLOMA VIRUS.

INFLUENZA VACCINE

SB00189: AN ACT ALLOWING MEDICAL ASSISTANTS TO ADMINISTER INFLUENZA VACCINE.

SB01124: AN ACT PROVIDING ESSENTIAL PLANNING FOR CATASTROPHIC EVENTS IMPACTING THE STATE.

SB01195: AN ACT CONCERNING ADMINISTRATION OF INFLUENZA AND PNEUMOCOCCAL POLYSACCHARIDE VACCINES BY LICENSED HOME HEALTH CARE AGENCY STAFF.

HB 05512: AN ACT ESTABLISHING A BULK PURCHASING INFLUENZA VACCINE PILOT PROGRAM.
(Continued from page 2 HPV target groups)

years and older. For women younger than 40 years, those most likely to have been infected at a young age, Hispanic, black or urban residents were 2.9, 1.6 and 1.8 times more likely than white women to be diagnosed with cervical cancer (Table 1).

Table 1. Cervical Cancer Incidence Rates by Age-Group and Race-ethnicity, CT 1994-2003

<table>
<thead>
<tr>
<th></th>
<th>Age &lt;40 yrs</th>
<th>Age &gt;40 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incidence*</td>
<td>RR**</td>
</tr>
<tr>
<td>Overall</td>
<td>1.6</td>
<td>5.9</td>
</tr>
<tr>
<td>White Race</td>
<td>1.4</td>
<td>6.1</td>
</tr>
<tr>
<td>Black Race</td>
<td>2.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
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<td>2.9</td>
</tr>
<tr>
<td>Urban Residence</td>
<td>2.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

*Per 100,000 women in specified age and race ethnic group
**Rate ratio

Editorial Note:
In 2007, it is estimated that 11,150 new cases of invasive cervical cancer will be diagnosed in the United States. Approximately 3670 women will die that same year as a result of this disease (1). Given that 25% of girls report being sexually active by age 15 years (2) and the rapid rate at which exposure to HPV occurs after sexual debut, it is essential to vaccinate girls aged 11-12 years to get full benefit of the vaccine. However, given the spectrum of onset of sexual debut and the fact that exposure to HPV types 16 and 18 may not occur immediately, it is also important to make vaccine available to all females aged 13-26 years, particularly teenagers in recognized risk groups.

In Connecticut, the data on cervical cancer, as well as other sexually transmitted diseases such as gonorrhea and chlamydia, show that Hispanic and black teenage females are at particular risk. Thus, efforts should be made to target them with HPV vaccine.

References

MMWR publishes HPV recommendations for HPV vaccination. These can be read at: http://www.cdc.gov/mmwr/pdf/rr/rr56e312.pdf


The article concludes that a second dose of varicella vaccine could improve any waning immunity and improve primary vaccine failure.