Increase in Meningococcal Group W cases in UK
New Vaccine for teenagers (aged 14-18 years) in UK

**UK Information**
The UK plan to introduce a Men ACWY vaccine for all aged 14-18 years this summer. This vaccine will replace their MenC routine adolescent booster. There is concern in the UK about an increase in cases of meningococcal Group W caused by a particularly virulent strain. Although the total number of meningococcal cases in England has been falling since the early 2000s, Men W infections have increased from only 22 cases in 2009 to 117 in 2014. Currently Men W alone accounts for almost a quarter of all meningococcal infections in England.

**Irish Epidemiology**
In Ireland to date, we have not seen an increase in cases of meningococcal disease caused by the Group W strain. For the last 6 years there has been an average of 1 case per year (range 0 – 2 cases/year). Two cases were recorded in the first quarter of 2015. The Irish Health Protection Surveillance Centre is monitoring the number of cases to ensure that any increase is detected early.

**Irish Guidelines**
At present there are no plans to introduce Men ACWY adolescent booster in Ireland. The MenC adolescent booster programme in first year of second level school will continue. However, if there is evidence of an increase in cases of meningococcal Group W, the National Immunisation Advisory Committee will review the situation.

**UK MenB vaccination programme starts this autumn**
The UK plan to include MenB vaccine in their primary childhood vaccination schedule from September 2015. The vaccine will be given at 2 and 4 months, with a booster at 12-13 months.

In Ireland, the decision regarding the introduction of the MenB vaccine is still under consideration. At present, it is not included as part of the childhood immunisations. Parents may choose to have their children vaccinated but the vaccine must be obtained privately.


**Pneumococcal disease outbreak in welders**
An outbreak of four confirmed cases of invasive pneumococcal disease (IPD) in individuals occupationally exposed to welding fumes at a Belfast shipyard, has recently been reported in Northern Ireland. All cases were hospitalised.

Welders have an increased risk of IPD, and although not fully understood, this may relate to components of the fumes serving as a nutrient to increase adherence of the pneumococci to the lung tissue or inhalation of the fumes causing damage to the lungs’ immune defences.

The Irish Immunisation Guidelines include individuals with occupational exposure to metal fumes (i.e. welders) in the clinical risk groups recommended to have pneumococcal polysaccharide vaccine.

Common Queries

Q. What should happen if a child moves, or a syringe leaks, when giving a vaccine and some of the dose is lost?
A: When some of the vaccine is lost (e.g. patient moves, syringe leaks), it is difficult to judge how much vaccine the patient received. You should not count it as a valid vaccination. If it was an inactivated vaccine, you should re-immunise the person as soon as possible, even at the same visit. If it was a live vaccine, a further dose should be given if you detect the error on the same day, otherwise wait 4 weeks to give the next dose. However, if part of an oral vaccine (rotavirus) was spat out, count the dose and do not administer a second dose.

Q. Can infant vaccines ever be given early?
A: The table below gives the optimal and minimum recommended ages and intervals between doses of vaccines. Adherence to the optimal recommended ages and intervals have been shown to provide the best immune response. Every effort should be made to comply with the recommended ages and intervals. Minimum age and minimum intervals should ONLY be used in exceptional circumstances (e.g. imminent overseas travel). In these instances, the minimum recommended age and interval as given in this table can be used. This accelerated schedule should not be used routinely and remaining doses should be given at the recommended intervals to ensure the best protection.

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<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 1 to Dose 2</th>
<th>Dose 2 to Dose 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age</td>
<td>Interval</td>
<td></td>
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<tr>
<td></td>
<td>Optimal</td>
<td>Minimum</td>
<td>Optimal</td>
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<tr>
<td>6 in 1</td>
<td>2 months</td>
<td>6 weeks</td>
<td>2 months</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(4 months after Dose 1)</td>
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<tr>
<td>MenC</td>
<td>2 months</td>
<td>6 weeks</td>
<td>2 months</td>
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<td></td>
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<td></td>
<td>(over 12 months of age)</td>
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<tr>
<td>MMR</td>
<td>12 months</td>
<td>6 months¹</td>
<td>1 month¹</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(over 12 months of age)</td>
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<tr>
<td>PCV</td>
<td>2 months</td>
<td>6 months</td>
<td>2 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(over 12 months of age)</td>
</tr>
</tbody>
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¹ In an outbreak if a child receives MMR under 12 months they should have a repeat MMR vaccination at 12 months of age, at least one month after the first vaccine, with a further dose at 4-5 years of age.
² 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 4-5 years of age.


Q. What happens if a dose is given before the minimum recommended age or interval?
A: If a vaccine is inadvertently given before the minimum age or interval recommended, it should not be considered as part of the primary series as there may be a sub-optimal immune response. The dose should be disregarded and another dose given at the recommended time, at least 1 month after the disregarded dose. However, giving a dose 4 days or less before the recommended interval is unlikely to have a significant adverse effect on the immune response and does not need to be repeated.

Vaccines should never knowingly be given before the minimum recommended age or interval, even in exceptional circumstances. The exception is MMR which may be recommended from age 6 months in specific outbreak or contact situations.