

Notice to Readers: Pneumococcal Conjugate Vaccine Shortage Resolved



Weekly

May 16, 2003 / 52(19);446-447

Persons using assistive technology might not be able to fully access information in this file. For assistance, please send e-mail to: mmwrq@cdc.gov. Type 508 Accommodation in the subject line of e-mail.

In February 2000, Prevnar™, a 7-valent pneumococcal conjugate vaccine manufactured by Wyeth Lederle Vaccines (Pearl River, New York), was licensed for use among infants and young children. Beginning in August 2001, the supply of Prevnar™ failed to meet demand, resulting in shortages for health-care providers and health departments. To conserve the limited supply and ensure protection of children at highest risk, CDC published interim recommendations for vaccination that called for withholding vaccine from healthy children aged ≥ 2 years and deferring some doses for healthy children aged < 2 years (1,2). Despite the shortage, introduction of the vaccine has been associated with a 69% decline in invasive disease among children aged < 2 years through 2001 (78% for vaccine serotypes and 50% for vaccine-related serotypes) (3).

Vaccine production and deliveries are now adequate to permit a return to the routine vaccination schedule (4). According to data from CDC tracking systems and the manufacturer, the average number of vaccine doses delivered monthly for each of the preceding 3 months exceeded the monthly estimated average national need, and all back orders have been filled in both the public and private sectors.

According to the original Advisory Committee on Immunization Practices recommendations (4) and more recent guidance from CDC (5), all children aged < 24 months and 24--59 months who are at increased risk for pneumococcal disease (e.g., children with sickle cell disease or anatomic asplenia, chronic illness, a cerebrospinal fluid leak, a cochlear implant, or an immunocompromising condition) should be administered the pneumococcal conjugate vaccine. In addition, providers should consider vaccine for all other children aged 24--59 months, with priority given to children aged 24--35 months, American Indian/Alaska Native and black children, and those who attend group child care.

A catch-up schedule is provided for children who are incompletely vaccinated (Table). The highest priority for catch-up vaccination is to ensure that children aged < 5 years at high risk for invasive pneumococcal disease because of medical conditions have received a complete series. Second priorities include vaccination of healthy children aged < 24 months who have not received any doses of pneumococcal conjugate vaccine and healthy children aged < 12 months who have not yet received 3 doses.

Because of the frequency of health-care provider visits for children during their first 18 months, catch-up vaccination might occur at regularly scheduled visits for most children who receive vaccines from their primary-care provider; special notification should be considered for children who have completed their 15-month visit and are not scheduled to be seen again before the visit at age 2 years. Programs that provide vaccinations but do not see children routinely for other reasons also should consider a notification process to contact undervaccinated or unvaccinated children.

Reporting Invasive Pneumococcal Disease Among Vaccinees

CDC is investigating situations in which invasive pneumococcal disease occurs despite vaccination. Health-care providers are encouraged to report invasive pneumococcal disease occurring in children aged <5 years who have received ≥ 1 doses of pneumococcal conjugate vaccine to CDC through state health departments. If pneumococcal isolates are available from vaccinated children, CDC will perform serotyping to determine whether the strain is a type included in the vaccine. Additional information is available at <http://www.cdc.gov/nip/diseases/pneumo/PCV-survrpts/default.htm>.

References

Table

TABLE. Recommended regimens for pneumococcal conjugate vaccine among children with a late start or lapse in vaccine administration

| Age at examination (mos) | Previous pneumococcal conjugate vaccination history | Recommended regimen* |
|--------------------------|---|--|
| 2–6 | 0 doses | 3 doses 2 months apart, 4th dose at age 12–15 months |
| | 1 dose | 2 doses 2 months apart, 4th dose at 12–15 months |
| | 2 doses | 1 dose, 4th dose at 12–15 months |
| 7–11 | 0 doses | 2 doses 2 months apart, 3rd dose at 12–15 months |
| | 1 or 2 doses before age 7 months | 1 dose at 7–11 months, with another dose at 12–15 months (≥ 2 months later) |
| 12–23 | 0 doses | 2 doses ≥ 2 months apart |
| | 1 dose before age 12 months | 2 doses ≥ 2 months apart |
| | 1 dose at ≥ 12 months | 1 dose ≥ 2 months after the most recent dose |
| | 2 or 3 doses before age 12 months | 1 dose ≥ 2 months after the most recent dose |
| 24–59 | | |
| Healthy children† | Any incomplete schedule | Consider 1 dose ≥ 2 months after the most recent dose |
| High risk§ | <3 doses | 1 dose ≥ 2 months after the most recent dose and another dose ≥ 2 months later |
| | 3 doses | 1 dose ≥ 2 months after the most recent dose |

* For children vaccinated at age <1 year, the minimum interval between doses is 4 weeks. Doses administered at ≥ 12 months should be at least 8 weeks apart.

† Providers should consider 1 dose for healthy children aged 24–59 months, with priority to children aged 24–35 months, American Indian/Alaska Native and black children, and those who attend group child care centers.

§ Children with sickle cell disease, asplenia, human immunodeficiency virus infection, chronic illness, cochlear implant, or immunocompromising condition.

Return to top.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites. URL addresses listed in *MMWR* were current as of the date of publication.

Disclaimer All *MMWR* HTML versions of articles are electronic conversions from ASCII text into HTML. This conversion may have resulted in character translation or format errors in the HTML version. Users should not rely on this HTML document, but are referred to the electronic PDF version and/or the original *MMWR* paper copy for the official text, figures, and tables. An original paper copy of this issue can be obtained from the Superintendent of Documents, U.S. Government Printing Office (GPO), Washington, DC 20402-9371; telephone: (202) 512-1800. Contact GPO for current prices.

****Questions or messages regarding errors in formatting should be addressed to mmwrq@cdc.gov.**

Page converted: 5/15/2003

This page last reviewed 5/15/2003