# Changes to the Australian Immunisation Handbook 8th Edition

The following changes to the Australian Immunisation Handbook, 8th Edition 2003, were approved on 9 December 2004 by the National Health and Medical Research Council (NHMRC). The changes will be made to the electronic Handbook in the near future. The locations of the changes are described for both the A5 hardcopy version and the electronic version.

## Adrenaline

A5 hardcopy: Page 33, under the heading 'Adrenaline 1:10 000 (one in ten thousand)', end of the first paragraph.
Electronic: Handbook – Vaccination procedures and the standard vaccination schedule – 1.6 Adverse Events Following Immunisation (AEFI) – Adrenaline dose – Adrenaline 1:10 000 (one in ten thousand) – end of the first paragraph.

Add:

"*NHMRC recommends 1:10 000 adrenaline be administered by IM injection, in conflict with the product information, which states the route of administration to be SC injection.*"

## Inactivated poliomyelitis vaccine (IPV)

A5 hardcopy: Page 38, second paragraph.
Electronic: Handbook – Vaccination procedures and the standard vaccination schedule – 1.7 The Australian Standard Vaccination Schedule – Notes – last paragraph.

Replace:

"*IPV is preferred to OPV, subject to the availability of IPV-combination vaccines, but both IPV and OPV are acceptable for use in the ASVS.*"

With:

"*IPV is preferred to OPV, subject to the availability of IPV or IPV-combination vaccines, but both IPV and OPV are acceptable for use in the ASVS.*"

### Online catch-up calculator

A5 hardcopy: change occurs on page 42, under the web address for the catch-up calculator.
Electronic: change occurs under Handbook – Vaccination procedures and the standard vaccination schedule – 1.9 Catch-Up Vaccination– Introduction' – under the web address for the catch-up calculator.

Add:

"*Note: Information contained in the catch-up calculator is not maintained by NHMRC.*"

### Catch-Up Vaccination

A5 hardcopy: change occurs on page 45, Table 1.9.1: Minimum intervals between vaccine doses – a guide for planning catch-up schedules.
Electronic: change occurs under Handbook – Vaccination procedures and the standard vaccination schedule – 1.9 Catch-Up Vaccination – Table 1.9.1: Minimum intervals between vaccine doses – a guide for planning catch-up schedules'.

Change:

For the vaccines OPV and IPV, "*NA*" should be replaced with "*1 month*" in the table for the time between doses 3 and 4 of these vaccines.

### Cholera

A5 hardcopy: replace chapter 3.4, pages 118 to 121.
Electronic: replace chapter under Handbook – Vaccines listed by disease – 3.4 Cholera.

Replace:

The existing chapter 3.4 with the updated chapter (below) that includes a new cholera vaccine and other updated information.

**What's new in this chapter:**
A new vaccine, "Dukoral", has been added, and information about its administration, safety and effectiveness has been included.

## 3.4 CHOLERA

### Bacteriology

Cholera is caused by enterotoxin producing *Vibrio cholerae* of serogroups 01 and 0139. Serogroup 01 includes two biotypes (classical and El Tor), each of which includes organisms of Inaba, Ogawa and Hikojima serotypes. The ability of *V. cholerae* to persist in water is determined by the temperature, pH, salinity and availability of nutrients; it can survive under unfavourable conditions in a viable dormant state.[1]

## Clinical features

Cholera is characterised by sudden onset of painless, profuse watery diarrhoea. Dehydration, metabolic acidosis and hypotension may soon follow. If untreated, more than half the severe cases will die. Mild cases also occur, as does subclinical infection.[1]

## Epidemiology

Cases of cholera in Australia (about 6 per year) almost always occur in individuals who have been infected in endemic areas of Asia, Africa, the Middle East, South America or parts of Oceania.[2] In 1977 a locally acquired case led to the discovery of *V. cholerae* in some rivers of the Queensland coast.[3] Because of this, health workers should be aware that sporadic cases of cholera may, on rare occasions, follow contact with estuarine waters. The disease is usually transmitted via food and water contaminated with human excreta. Shellfish obtained from contaminated waters have also been responsible for outbreaks.[1]

As the incubation period of the disease may extend up to 5 days, surveillance of household contacts or those exposed to a possible common source should be maintained for 5 days from the date of last exposure. Stool cultures may be taken from close contacts if required. Food handlers should not be allowed to return to work until 2 consecutive stool samples, taken at least 24 hours apart, are negative. Contacts should also be advised to maintain high standards of personal hygiene to avoid becoming infected. Cases should be reported immediately to the public health authorities.

## Vaccines

**Orochol** – CSL Vaccines (live recombinant oral vaccine consisting of attenuated CVD 103-HgR based on *V. cholerae* 01 Classical Inaba strain 569b). A single dose of one double chambered sachet contains 2–10x$10^9$ live *V. cholerae* CVD 103-HgR bacteria + lactose + aspartame + sucrose amino acid mixture + ascorbic acid + sodium bicarbonate.

**Dukoral** – Aventis Pasteur (inactivated whole-cell *V. cholerae* 01 in combination with a recombinant cholera toxin B subunit (rCTB). Each dose contains heat and formalin inactivated Inaba, Ogawa, classic and El Tor strains of *V. cholerae* 01, 2.5x$10^{10}$ vibrios of each, combined with rCTB 1 mg. The vaccine is a 3 ml water suspension in a glass vial, with sodium phosphate monobasic + dibasic dihydrate, + sodium chloride. The buffer is in a sachet of effervescent granules of anhydrous sodium carbonate + sodium bicarbonate + anhydrous citric acid + raspberry flavour.

Trials of the safety and immunogenicity of oral vaccines, both killed and live attenuated, have been carried out in the United States, Thailand, Indonesia, Chile, Peru and Switzerland.[4-9] A randomised, double-blind, placebo-controlled efficacy trial of one dose of CVD 103-HgR live oral vaccine conducted in Indonesia from 1993 to 1997 involving 67 508 persons aged 2 to 41 years was unable to demonstrate protection because cholera incidence was lower than expected.[10] Orochol® will not provide protection against *V. cholerae 0139.*

Trials of the inactivated vibrio combined with rCTB vaccine have been done mainly in Bangladesh and Peru.[7,11-14] In Bangladesh, a two dose regimen showed protective efficacy of 44% in children 2-6 years of age and 76% in adults at the end of one year, and 33% and 60% respectively after two years. The studies in Peru showed an overall effectiveness of 61% in 2-65 year olds.

A study in short term Finnish tourists[15] showed the vaccine provided a 60% reduction in diarrhoea caused by heat-labile toxin producing enterotoxigenic *E. coli* (LT-ETEC). A study in Bangladesh, an endemic area, showed 67% protection against LT-ETEC for three months only.[16] (*Level of evidence II*). It is possible that the inactivated vaccine may prevent the small proportion of travellers' diarrhoea that is caused by heat-labile toxin producing enterotoxigenic *E. coli* (LT-ETEC).

## Transport, storage and handling

Store in refrigerator at between 2°C to 8°C. Do not freeze. Protect from light.

## Dosage and administration

Oral live cholera vaccine is administered orally in a single dose and boosters are currently recommended every 6 months. It should not be administered to children under 2 years of age.

Oral live cholera vaccine should not be given to anyone on antimicrobials and should be given one hour before a meal.

The concomitant administration of chloroquine has been shown to decrease the immune response to the oral live vaccine. Chloroquine should not be administered sooner than one week after vaccination.

Yellow fever vaccine and oral poliomyelitis vaccine (OPV) may be administered at the same time as oral live and inactivated cholera vaccines.

There should be an interval of at least 8 hours between administration of oral live or inactivated cholera and oral typhoid vaccines, as the buffer in the cholera vaccines may affect the transit of the capsules of oral typhoid vaccine through the gastrointestinal tract.

Orochol is prepared for administration by emptying the contents of the sachet into 100mL of cold or lukewarm water and stirring vigorously for 5 to 10 seconds. It should *not* be suspended in milk, juice or carbonated drinks as these affect the buffer in the vaccine, and interfere with immunogenicity.

Dukoral is administered orally after dissolving the buffer granules in a glass of 150mL water and adding the vaccine to the solution. For children 2-6 years, half the amount of buffer is poured away before adding the vaccine. Two doses are required, given a week apart. If the second dose is not administered within 6 weeks, re-start the vaccination.

Food and drink should be avoided two hours before and one hour after administration of the inactivated cholera vaccine, as it is acid labile.

## Recommendations

Despite the endemicity of cholera in some countries often visited by Australians, routine cholera vaccination is not recommended as the risk to travellers is very low. Careful and sensible selection of food and water is of far greater importance to the traveller than vaccination. However, cholera vaccine may be offered to travellers to rural areas of highly endemic countries.[17] Vaccination against cholera is not an official requirement for entry into any foreign country.

## Adverse events and precautions

No serious adverse events have been reported from the oral live vaccine. However, as Orochol is a live vaccine, the theoretical benefits need to be weighed against the potential risks before it is administered to immunosuppressed individuals. The oral inactivated vaccine is uncommonly (<1%) associated with severe abdominal cramping.

As with other live vaccines, the oral live cholera vaccine should be used with caution in individuals who have close contact with those who are immunocompromised (transmission of vaccine vibrios to up to 6% of household contacts has been observed in some studies). It should be used with caution in individuals with phenylketonuria because it contains aspartame.

## Contraindications

- Oral live and inactivated cholera vaccines are not recommended for children under 2 years of age.
- Previous anaphylactic reaction to that particular vaccine or to any component of that particular vaccine.
- HIV-infected individuals – although the oral live cholera vaccine has been shown to cause a transient increase in viral load in HIV-infected individuals,[18] a trial in Mali showed the vaccine to be safe and immunogenic in HIV-infected adults.[19] Thus for HIV-infected adults travelling to or working in endemic areas, the theoretical benefits need to be weighed against the potential risks of cholera vaccination. The oral inactivated vaccine has not been studied in HIV infected individuals and could result in transient increase in viral load. Therefore its use is not recommended in such individuals.
- Postpone administration during acute febrile illness or acute gastrointestinal illness with persistent diarrhoea or vomiting.

## Use in pregnancy

There is inadequate information on the use of oral live and inactivated cholera vaccines during pregnancy and breast feeding.[17]

## Conflicts with product information

None.

## Reference List


1. Seas C, Gotuzzo E. *Vibrio cholerae*. In: Mandell GL, Bennett JE, Dolin R, editors. Mandell, Douglas and Bennett's principles and practice of infectious diseases. 5th ed. Philadelphia: Churchill Livingstone; 2000.

2. Communicable Diseases Network Australia - National Notifiable Disease Surveillance System, personal communication. Notifications of Cholera received by State and Territory health authorities in the period of 1991 to 2001 and year-to-date notifications for 2002 by year-month. http://www.health.gov.au/pubhlth/cdi/nndss/year008.htm

3. Rao A, Stockwell BA. The Queensland cholera incident of 1977. 1. The index case. *Bulletin of the World Health Organization* 1980;58:663-4.

4. Levine MM, Kaper JB, Herrington D, et al. Safety, immunogenicity, and efficacy of recombinant live oral cholera vaccines, CVD 103 and CVD 103-HgR. *Lancet* 1988;2:467-70.

5. Tacket CO, Losonsky G, Nataro JP, et al. Onset and duration of protective immunity in challenged volunteers after vaccination with live oral cholera vaccine CVD 103-HgR. *Journal of Infectious Diseases* 1992;166:837-41.

6. Lagos R, San Martin O, Wasserman SS, et al. Palatability, reactogenicity and immunogenicity of engineered live oral cholera vaccine CVD 103-HgR in Chilean infants and toddlers. *Pediatric Infectious Disease Journal* 1999;18:624-30.

7. Clemens JD, Sack DA, Harris JR, et al. Field trial of oral cholera vaccines in Bangladesh: results from three-year follow-up. *Lancet* 1990;335:270-3.

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9. Kotloff KL, Wasserman SS, O'Donnell S, et al. Safety and immunogenicity in North Americans of a single dose of live oral cholera vaccine CVD 103-HgR: results of a randomized, placebo-controlled, double-blind crossover trial. *Infection & Immunity* 1992;60:4430-2.

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11. Clemens JD, Sack DA, Harris JR, et al. Field trial of cholera vaccines in Bangladesh. *Lancet* 1986;2:124-27.

12. Clemens JD, Stanton BF, Chakraborty J, et al. B subunit-whole cell and whole cell and whole-cell only oral vaccines against cholera: studies on reactogenicity and immunogenicity. *Journal of Infectious Diseases* 1987;155:79-85.

13. Taylor DN, Cardenas V, Sanchez JL, et al. Two-year study of the protective efficacy of the oral whole cell recombinant B subunit cholera vaccine in Peru. *Journal of Infectious Diseases* 2000; 181:1667-73.

14. Sanchez JL, Vasquez B. Protective efficacy of whole-cell/recombinant-B-subunit cholera vaccine in Peruvian military recruits. *Lancet* 1994;344:1273-76.

15. Peltola H, Siitonen A, Kyronnseppa, et al. Prevention of traveller's diarrhoea by oral B-subunit/whole cell cholera vaccine. *Lancet* 1991; 338:1285-89.

16. Clemens JD, Sack DA, Harris JR et al. Cross-protection by B subunit-whole cell cholera vaccine against diarrhoea associated with heat-labile toxin-producing enterotoxigenic *Escherichia coli*: results of a large-scale field trial. *Journal of Infectious Diseases* 1988;158:372-77.

17. Cholera vaccines. *Weekly Epidemiological Record* 2001;76:117-24.

18. Ortigao-de-Sampaio MB, Shattock RJ, Hayes P, et al. Increase in plasma viral load after oral cholera immunization of HIV-infected subjects. *AIDS* 199812:F145-50.

19. Perry RT, Plowe CV, Koumare B, et al. A single dose of live oral cholera vaccine CVD 103-HgR is safe and immunogenic in HIV-infected and HIV-noninfected adults in Mali. *Bulletin of the World Health Organization* 1998;76:63-71.

## Haemophilus influenzae type b

A5 hardcopy: change occurs on page 132, last paragraph, fifth sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.7 Haemophilus Influenzae Type B (HIB) – Recommendations – viii. Management of contacts of a child with invasive Hib disease.

Replace:

*"Similarly, if the index case attends a child-care facility for more than 18 hours a week, and other children under 24 months of age in this facility are in close contact, rifampicin chemoprophylaxis should also be given to all contacts (including staff) if any of the close contacts are inadequately vaccinated."*

With:

"*Similarly, if the index case attends a child day-care facility for more than 18 hours a week, rifampicin should be given to all children and staff who were in the same room group (as the case) in the 7 days preceding the case's onset, provided that at least one of these close contacts is a child under 24 months of age who is inadequately vaccinated. Although there may have been some intermingling of all the children at the facility at the beginning and end of the day, this is usually of a short duration only and not enough to justify extending the use of rifampicin*."

## Hepatitis A chapter

A5 hardcopy: change occurs on page 139, Table 3.8.1: Recommended dosages and schedules for use of the inactivated hepatitis A vaccines.

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Electronic: change occurs under Handbook – Vaccines listed by disease – 3.8 Hepatitis A – Dosage and administration – Table 3.8.1: Recommended dosages and schedules for use of the inactivated hepatitis A vaccines.

Change:

For VAQTA Paediatric/Adolescent vaccine, change the vaccinee's age (yrs) from "*2-17*" to "*1-17*".

## Influenza

A5 hardcopy: change occurs on page 168, under the 'Vaxigrip' dot point.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.11 Influenza – Vaccines – under the 'Vaxigrip' dot point.

Add new dot point:

"***Vaxigrip Junior*** *– Aventis Pasteur (inactivated influenza vaccine). 0.25 mL pre-filled syringe; also contains formaldehyde and buffered saline. May also contain traces of neomycin.*"

A5 hardcopy: change occurs on page 169, second paragraph, after the second sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.11 Influenza –Vaccines – second paragraph, after the second sentence.

Add:

"*Vaxigrip Junior contains 7.5 µg of viral haemagglutinin of each of the 3 strains found in the adult formulations.*"

## Japanese Encephalitis

A5 hardcopy: change occurs on page 179, third paragraph.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.12 Japanese Encephalitis – Recommendations – i.Travellers – last paragraph.

Replace paragraph:

"*JE vaccination is also recommended for travellers intending to spend a month or more in the Western Province of Papua New Guinea, particularly if the travel is during the wet season. Current understanding of the ecology of the JE virus elsewhere in Papua New Guinea is fragmentary and unsubstantiated. Therefore no definitive recommendations about JE vaccination for travellers in other parts of Papua New Guinea can be made at the current time.*"

With the following dot point:

"*travellers intending to spend a month or more in Papua New Guinea, particularly if the travel is during the wet season.*"

## Meningococcal infections

A5 hardcopy: change occurs on page 199, third dot point.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.14 Meningococcal Infections – Recommendations – Meningococcal C conjugate vaccines, last dot point.

Replace:

"*any children, adolescents or young adults who have had previous meningococcal disease (including group C disease). These persons should receive the vaccine regardless of infecting serogroup. This is because young children may not have mounted an optimal immune response to the infection and older persons may have an unrecognised risk factor for meningococcal disease. Vaccine may be administered on discharge from hospital, or when the person recovers from infection*."

With:

"*any children, adolescents or young adults who have had previous meningococcal disease (including group C disease). Previous disease is not a contraindication to receiving MenCCV because: the reported infecting serogroup may not be correct; young children may not have mounted an optimal immune response to the infection; and older persons may have an unrecognised risk factor for meningococcal disease.*"

## Pertussis

A5 hardcopy: change occurs on page 211 before the heading '(iii) The public health management of pertussis'.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.16 Pertussis – Recommendations – (ii) Booster doses – Adults and older children, after last dot point.

Add paragraph:

"***Minimum interval between dTpa and other tetanus-containing vaccines***
*dTpa can be administered at any time following a previously administered dose of tetanus toxoid containing vaccine (expert opinion)*."

A5 hardcopy: change occurs on page 212, second paragraph, third sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.16 Pertussis – Recommendations – (iii) The public health management of pertussis – Management of cases – second paragraph, third sentence.

Replace:

"*The dose of erythromycin for children is 10 mg/kg/dose up to 250 mg orally 6-hourly for 7 days; the dose for adults in 250 mg orally 6-hourly for 7 days.*"

With:

"*The dose for babies 0 to 7 days old (regardless of duration of gestation) is 10 mg/kg/dose orally 12-hourly for 7 days; the dose for babies 8 to 28 days old is 10 mg/kg/dose orally 8-hourly for 7 days; the dose for babies and children older than 28 days is 10 mg/kg/dose orally 6-hourly for 7 days; the dose for adults is 250 mg orally 6-hourly for 7 days.*"

## Pneumococcal infections

A5 hardcopy: change occurs on pages 229, 230, 231 and 232, Tables 3.18.3, 3.18.4 and 3.18.5.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.18 Pneumococcal Infections – Recommendations – 7-valent pneumococcal conjugate vaccine – Tables 3.18.3, 3.18.4 and 3.18.5.

Replace table 3.18.3 with the following:

**PNEUMOCOCCAL VACCINATION: Medical-risk children <5 years of age**
NB: 7vPCV = Prevenar; 23vPPV = Pneumovax

**DELAYED-START SCHEDULE** (when start of 7vPCV has been delayed after 2 months of age)

| Age at first dose of 7vPCV | Primary 7vPCV schedule | Booster schedule |
|---|---|---|
| 3–6 months | 3 doses, 1-2 months apart | 7vPCV at 12 months of age;<br>23vPPV at 4-5 years of age |
| 7–11 months | 2 doses, 1-2 months apart | 7vPCV either 2 months after second dose or at 12 months of age (whichever is later);<br>23vPPV at 4-5 years of age |
| 12–59 months | 2 doses, 2 months apart | 23vPPV at 4-5 years of age |

**NB: Delayed-start and catch-up doses can be given a minimum of one month apart for children less than 12 months of age.**

**CATCH-UP SCHEDULE** (when one or more doses of 7vPCV have been missed)

| Age when child first presents for catch-up | Number of previous doses of 7vPCV | Catch-up schedule |
|---|---|---|
| 5-6 months | 1 dose | Second dose 7vPCV now;<br>third dose 1-2 months later;<br>booster dose at 12 months of age;<br>23vPPV at 4-5 years of age |
| 7-11 months | 1 or 2 doses | A dose 7vPCV now;<br>booster dose 7vPCV either 2 months after previous dose or at 12 months of age (whichever is later);<br>23vPPV at 4-5 years of age |
| 12-59 months | Any incomplete schedule | A dose 7vPCV now;<br>23vPPV at 4-5 years of age |

NB: Delayed-start and catch-up doses can be given a minimum of one month apart for children less than 12 months of age.

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Replace table 3.18.4 with the following:

**PNEUMOCOCCAL VACCINATION: Indigenous children <2 years of age in NT, Qld, SA and WA**

NB: 7vPCV = Prevenar; 23vPPV = Pneumovax

**DELAYED-START SCHEDULE** (when start of 7vPCV has been delayed after 2 months of age)

| Age at first dose of 7vPCV | Primary 7vPCV schedule | Booster schedule |
|---|---|---|
| 3-6 months | 3 doses, 1-2 months apart | 23vPPV at 18 months or 2 years of age* |
| 7-17 months | 2 doses, 1-2 months apart | 23vPPV at 18 months or 2 years of age* |
| 18-23 months | 1 dose | 23vPPV either 2 months after dose of 7vPCV or at 18 months or 2 years of age*<br>(whichever is later) |

**NB: Delayed and catch-up doses can be given a minimum of one month apart for children less than 12 months of age.**

* The timing of the booster dose of 23vPPV varies between States and Territories. Contact your State or Territory Health Department for the appropriate timing of this dose.

**CATCH-UP SCHEDULE** (when one or more doses of 7vPCV have been missed)

| Age when child first presents for catch-up | Number of previous doses of 7vPCV | Catch-up schedule |
|---|---|---|
| 5-11 months | 1 dose | Second dose 7vPCV now; third dose 7vPCV 1-2 months later; 23vPPV at 18 months or 2 years of age* |
| 7-11 months | 2 doses | Third dose 7vPCV now; 23vPPV at 18 months or 2 years of age* |
| 12-23 months | 1 dose | Second dose 7vPCV now; 23vPPV at 18 months or 2 years of age* |
| 12-23 months | 2 doses | 23vPPV at 18 months or 2 years of age* |

NB: Delayed and catch-up doses can be given a minimum of one month apart for children less than 12 months of age.

- The timing of the booster dose of 23vPPV varies between States and Territories. Contact your State or Territory Health Department for the appropriate timing of this dose.

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Replace table 3.18.5 with the following:

**PNEUMOCOCCAL VACCINATION: Low-risk children <2 years of age (including Indigenous children in ACT, NSW, Tas and Vic)**
NB: 7vPCV = Prevenar; 23vPPV = Pneumovax

**DELAYED-START SCHEDULE** (when start of 7vPCV has been delayed after 2 months of age)

| Age at first dose of 7vPCV | Primary 7vPCV schedule | Booster schedule |
|---|---|---|
| 3-6 months | 3 doses, 1-2 months apart | None |
| 7-17 months | 2 doses, 1-2 months apart | None |
| 18-23 months | 1 dose | None |

**NB: Delayed and catch-up doses can be given a minimum of one month apart for children less than 12 months of age.**

**CATCH-UP SCHEDULE** (when one or more doses of 7vPCV have been missed)

| Age when child first presents for catch-up | Number of previous doses of 7vPCV | Catch-up schedule |
|---|---|---|
| 5-11 months | 1 dose | Second dose 7vPCV now; third dose 7vPCV 1-2 months later |
| 7-11 months | 2 doses | Third dose 7vPCV now |
| 12-23 months | 1 dose | Second dose 7vPCV now |
| 12-23 months | 2 doses | No further doses required |

NB: Delayed and catch-up doses can be given a minimum of one month apart for children less than 12 months of age.

## Poliomyelitis

A5 hardcopy: change occurs on page 237, under the heading 'Interchangeability of OPV and IPV', last sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.19 Poliomyelitis – Dosage and administration – Interchangeability of OPV and IPV – last sentence.

Replace:

"*Children commenced on OPV may complete their polio immunisation schedule using IPV-containing vaccines.*"

With:

"*Children commenced on OPV may complete their polio immunisation schedule using IPV or IPV-containing vaccines.*"

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A5 hardcopy: change occurs on page 237, under the heading 'Preterm infants'.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.19 Poliomyelitis – Dosage and administration – Preterm infants.

Replace:

"*Extra doses of IPV-containing vaccines are not needed for babies born prematurely.*"

With:

"*Extra doses of IPV or IPV-containing vaccines are not needed for babies born prematurely.*"

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A5 hardcopy: change occurs on page 240, under the heading 'Contraindications', first sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.19 Poliomyelitis – Contraindications – first sentence.

Replace:

"*IPV-containing vaccines are contraindicated in the following circumstances:*"

With:

*"IPV or IPV-containing vaccines are contraindicated in the following circumstances:"*

## Respiratory syncytial virus (RSV)

A5 hardcopy: change occurs on page 249, second paragraph, second sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.21 Respiratory Syncytial Virus – Vaccine – RSV immunoglobin – second paragraph, second sentence.

Remove:

"*Its use has not been studied in children with congenital heart disease, and it should not be used for such children.*"

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A5 hardcopy: change occurs on page 249, second paragraph, fourth sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.21 Respiratory Syncytial Virus – Vaccine – RSV immunoglobin – second paragraph, fourth sentence.

Replace:

"*The product was found to reduce hospitalisation by about 5% for both preterm and BDP babies*."

With:

"*The product was found to reduce the absolute risk of hospitalisation from about 10% to about 5% for both preterm and BPD babies.*"

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A5 hardcopy: change occurs on page 249, last paragraph, second sentence.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.21 Respiratory Syncytial Virus – Contraindications – last sentence.

Remove: "*It is also contraindicated in children with congenital heart disease.*"

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A5 hardcopy: change occurs on page 250, first paragraph.
Electronic: change occurs under Handbook – Vaccines listed by disease – 3.21 Respiratory Syncytial Virus – Conflicts with product information.

Replace:

"*NHMRC recommends that palivizumab is contraindicated in children with congenital heart disease; this is not a listed contraindication in the product information.*"

With:

"*None.*"

## Contact details

A5 hardcopy: change occurs on page 295 and the inside front cover
Electronic: change occurs under Handbook – Appendices – Appendix 1: Contact details for Commonwealth, State and Territory Government Health Authorities and Outbreak Control.

Change**:**

The contact number for Tasmania is now "*03 6222 7724* and *1800 671 738*" and the contact number for Victoria is now *"1300 882 008".*