

Canadian Immunization Guide, 2006, 7th Edition

Errata/Clarifications, March 2008

Part 3 – Recommended Immunization

Chapter entitled: *Immunization of Adults*

Page 102

In Table 6, Adult Immunization Schedule – Specific Risk Situations, the indication for Poliomyelitis (eighth row) should read as follows, for comprehensiveness:

“Travel to endemic area(s) *or any areas where the virus is known or suspected to be circulating, or other risk group*”

Chapter entitled: *Immunization of Immunocompromised Persons*

Page 123

Under the sub-section “Immunosuppressive therapy,” modifications were made to the first paragraph at the top of page 123 in order to clarify the timeframe for all types of vaccines:

“There is no contraindication to the use of any inactivated vaccine in these people, and particular attention should be paid to the completion of childhood immunizations, annual influenza immunization and pneumococcal immunization (with a booster after 3-5 years). Ideally, all appropriate *inactivated vaccines* should be administered to these individuals at least 14 days before the initiation of therapy. *If indicated, MMR should be administered at least 14 days before the initiation of therapy and varicella vaccine should be administered at least 6 weeks before the initiation of therapy.* If this cannot be done safely, a period of at least 3 months should elapse after immunosuppressive drugs have been stopped before administration of both inactivated and component vaccines (to establish immunogenicity, although inactivated vaccines can be administered if required for post-exposure or outbreak management) and live vaccines (to reduce the risk of dissemination). However, the interval may vary with the intensity of the immunosuppressive therapy, underlying disease and other factors. If immunosuppressive therapy cannot be stopped, inactivated or component vaccines should be given when the therapy is at the lowest possible level. Live vaccines are generally contraindicated, although the risk-to-benefit ratio for several of these vaccines can favour immunization if only low doses of immunosuppressive drugs are required and there is significant risk of wild-type infections (e.g. varicella vaccine in seronegative individuals).”

Page 126

With regard to the sub-section “Solid organ transplantation,” the fifth bullet from the top of page 126 has been updated as follows:

- ♦ “Varicella vaccine: recommended before transplantation for non-immune (as determined by serology) children and adults. Until further data are available, the same age appropriate dosage schedule as for healthy children may be followed. Susceptible persons awaiting solid organ transplants may be immunized with one to two doses of varicella vaccine (depending on their age), the last dose being given at least 6 weeks prior to transplantation. The suggested wait period makes vaccination practical mainly in the context of elective transplantation. The person should not be receiving immunosuppressive treatment at the time of vaccination.”

“Varicella vaccine is not recommended after solid-organ transplantation. Some experts have vaccinated children with varicella vaccine at least 6 months post-transplantation, when there was no evidence of organ rejection and the patient was deemed to be on minimal immunosuppressive agent(s). No serious adverse effects were noted, but the number of patients vaccinated was too small to make any conclusions about the safety of varicella vaccine in this immunocompromised population. More research is needed.”

Page 129

Please note that Table 8, Vaccination of Individuals with Immunodeficiency, should not include Oral cholera vaccine (last row) since it is not marketed in Canada.

Chapter entitled: *Immunization of Persons with Neurologic Disorders*

Page 132

Under the section "Neurologic events following immunization," the word “or” has been changed to “and” in the last sentence of the second paragraph:

“People with encephalopathy or encephalitis that develops within 7 days after immunization should be investigated. Those who have an alternative etiology for the encephalopathy (e.g., viral infection) or who recover fully by the next scheduled vaccination may be immunized without deferral. People with encephalopathy that persists *and* who have no alternative etiology should be referred to a specialist for further consultation and may be immunized if their condition is stable and found not to relate to immunization.”

Chapter entitled: *Immunization of Travellers*

Page 139

Please note that the International Certificate of Vaccination, as mentioned in the first and second paragraphs under the sub-section “Yellow fever,” has been renamed, and it is now called “the International Certificate of Vaccination or Prophylaxis,” according to the revised International Health Regulations 2005.

Page 142

As mentioned on page 8 in Table 1, Type and Contents of Vaccines Currently Approved for Use in Canada, the tickborne encephalitis (TBE) vaccine is marketed in Canada under the brand name FSME - IMMUN. This vaccine would belong under the section “Recommended Immunizations,” before the sub-section on Typhoid at the top of page 142. To identify travellers who are at risk of contracting the TBE virus, the Committee to Advise on Tropical Medicine and Travel (CATMAT) recommends that travel medicine professionals should consider the season of travel, travel itinerary, and the activities of the traveller. For additional information, please visit PHAC’s website for the CATMAT Statement on TBE (April 2006) at <<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/06pdf/acs-32-03.pdf>>.