

From the Chief Medical Officer
Dr Henrietta Campbell CB

HSS(MD)25/2005

To:

Directors of Public Health, HSS Boards
Consultants in Communicable Disease Control, HSS Boards
All General Practitioners (for dissemination to practice nurses)
All Locum General Practitioners
Chief Executives of HSS Boards
Chief Executives of HSS Trusts (for circulation to Occupational Health Departments)
Medical Directors, HSS Trusts
Directors of Nursing/Chief Nurses, HSS Boards
Directors of Nursing, HSS Trusts
Consultants in Respiratory Medicine
Dr Paul Jackson
Dr Sara Hedderwick
Dr Sharon Christie
Dr Delia Skan
Regional Epidemiologist (CDSC NI)
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Your Ref:

Our Ref: HSS(MD)25/2005

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Dear Colleague

CHANGES TO THE BCG VACCINATION PROGRAMME

This letter describes changes being introduced to the BCG vaccination programme. In summary:

- An improved targeted neonatal and others at risk based programme will replace the current schools programme for older children.

Those now recommended to receive BCG are:

- All infants living in areas where the incidence of TB is 40/100,000 or greater. (The Northern Ireland incidence of TB is 4/100,000)
- Infants whose parents or grandparents were born in a country with a TB incidence of 40/100,000 or higher.
- Previously unvaccinated new immigrants from high prevalence countries for TB.
- Children who would otherwise have been offered BCG through the schools programme will now be screened for TB risk factors, and tested and vaccinated if appropriate.

The contact, occupational and travel related recommendations remain unchanged.

The Mantoux test will replace the Heaf test as the standard method of tuberculin skin testing. Training in the use of the Mantoux method should be arranged locally. Supplementary training materials will be supplied by the Department.

Health and Social Services Boards are the lead in implementing the new BCG vaccination programme and should make appropriate commissioning arrangements. Any clinics which have been scheduled as part of the school BCG programme should be cancelled. A regional group will be convened to identify action required to take forward this new policy. It will consider how a selective BCG programme should be implemented and the issue of general TB control. An operational note on procedures to be followed and materials for Mantoux testing and phasing out of Heaf testing will be issued.

Further information on the changes to the programme are attached in an annex to this letter.

Thank you for your continued work on this important vaccination programme.

For further information please contact:

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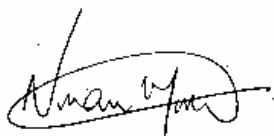
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Yours sincerely



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This letter is available at www.dhsspsni.gov.uk and also on the DHSSPS Extranet which can be accessed directly at <http://extranet.dhsspsni.gov.uk> or by going through the HPSS Web at <http://www.n-i.nhs.uk> and clicking on DHSSPS.

Background to the Changes to BCG Vaccination Policy

BCG vaccination was first introduced in the UK in the 1950s, and recommended for secondary school age children. At that time, around 50,000 cases of TB were reported each year in the UK, and cases occurred across most sectors of society. The age at which the immunisation was recommended represented the most effective use of the vaccine for the epidemiology that prevailed at that time. In the 1960s, selective immunisation of neonates born to new entrants to the UK from countries with high rates of TB was also introduced. This was due to the concern about the high rates of TB in these populations, and the fact that children born into these communities were at higher risk of infection than the general population. The UK approach, of vaccinating at secondary school age, was unique, with other countries either vaccinating all infants (if the epidemiology supported this) or vaccinating infants selectively or not using BCG at all.

Cases of TB in the UK fell from 50,000 per year in the 1950s to a nadir of 5,800 in the late 1980s. The epidemiology of TB in the UK also changed from a disease of the general population to one of predominantly high risk groups. Although total cases have increased steadily since the early 1990s to approximately 7,000 new reported cases a year, rates in the indigenous white population have fallen to very low levels. Highest rates are in particular risk groups: 60% of reported cases are in people born abroad, the rate being higher in certain ethnic groups in the first few years after they enter the country, and rates remain high in the children of these immigrants, wherever born. Other risk groups include contacts of cases, the homeless and those with HIV infection.

Review of the BCG Programme

The Joint Committee on Vaccination and Immunisation (JCVI) has reviewed all available scientific and epidemiological data and recommended that it is now time to stop the national schools based programme. Those at high risk will be identified in a selective programme.

The JCVI recommends that the following risk groups be offered BCG vaccination:

- **All infants living in areas where the incidence of TB is 40/100,000 or greater.**
- **Infants whose parents or grandparents were born in a country with a TB incidence of 40/100,000 or higher.**
- **Previously unvaccinated new immigrants from high prevalence countries for TB.**
- **Children who would otherwise have been offered BCG through the schools programme will be screened for risk factors, tested and vaccinated as appropriate.**

BCG vaccination should also continue to be offered to those at risk due to their occupation, such as health care workers, veterinary staff, staff of prisons; to contacts of known cases, and to those intending to live or work in high prevalence countries for extended periods (generally one month or longer).

In most parts of the country selective BCG programmes targeting 'at risk' groups have been operational for the last 20 years, and some areas have already stopped the schools part of the programme. Stopping the schools programme nationally will mean that local arrangements will have to be made to test and vaccinate children at risk of tuberculosis, who have not already been vaccinated and who will no longer be offered BCG through the schools programme.

In order to support the changes to the programme, the Department will continue to consult closely with primary medical services and front-line staff. Guidance and training materials will be produced and disseminated widely. This will include information on high incidence areas in England and high incidence countries. They will be based on good practice, with examples of what works to improve the effectiveness and delivery of services.

Implications for Skin Testing

Mantoux testing is the international standard for determining immunity to TB. Up to now the UK has used both Mantoux and the Heaf methods of administering tuberculin but has been the only country to widely use the Heaf method for screening before routine BCG vaccination.

The only manufacturer of Heaf strength tuberculin PPD will no longer be supplying tuberculin PPD. We are therefore recommending that Mantoux testing replaces Heaf testing.

The Department has obtained alternative supplies of tuberculin PPD for Mantoux testing manufactured by Statens Serum Institute (SSI) in Denmark. This is available as an unlicensed medicine in the UK. As current stocks of Heaf strength PPD run out, clinics need to change to the Mantoux method of tuberculin testing.

The Mantoux test involves an intradermal injection of tuberculin. This intradermal method is identical to that used to administer BCG vaccine. Where necessary, training on administering and interpreting the Mantoux test should be provided locally.

An operational note on procedures to be followed and materials on Mantoux testing and phasing out of Heaf testing will be issued later.

Immunisation Against Infectious Disease – The Green Book 1996

The new Green Book chapter on Tuberculosis will be available on the web in August. In the meantime, advice contained in the 1996 Green Book Immunisation Against Infectious Disease is still current, except where superseded by this new guidance.