

Responses Overview Active

Responses

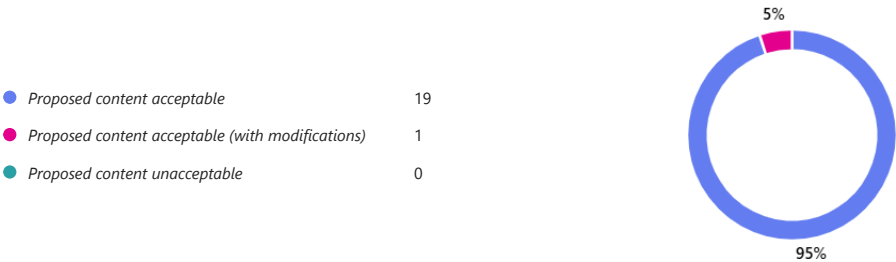
20

1. **UPDATED Content**

Section 2.1.1 Case management definitions

Factors favouring a diagnosis of primary measles infection: Updated content adopted from NIAC guidelines to include the following sentence "individuals born in Ireland before 1978 are likely to be immune through natural infection".

Refer to Working draft Section 2.1.1 Case management definitions to review updated content.



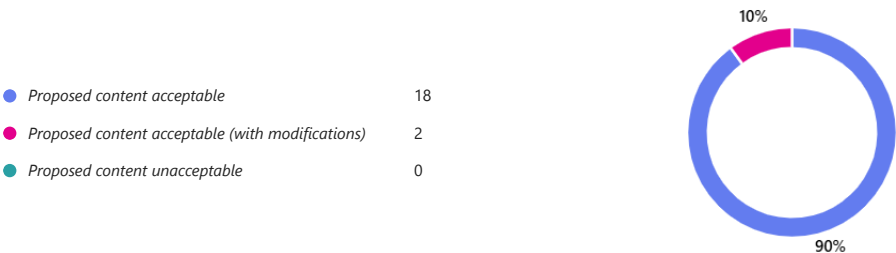
2. **NEW Content**

Section 2.1.1 Testing of index case

Add paragraph on serology; "Ideally, a serum sample should also be sent however it is recognised that phlebotomy may not be feasible on younger patients or if it is not possible to safely bring a patient into a primary care setting due to IPC limitations. The added value of the serum sample is that measles IgG can also be detected, and this provides information regarding the immune status of an individual following exposure for patient management and also to determine if the infection is a primary infection or breakthrough (reinfection) infection".

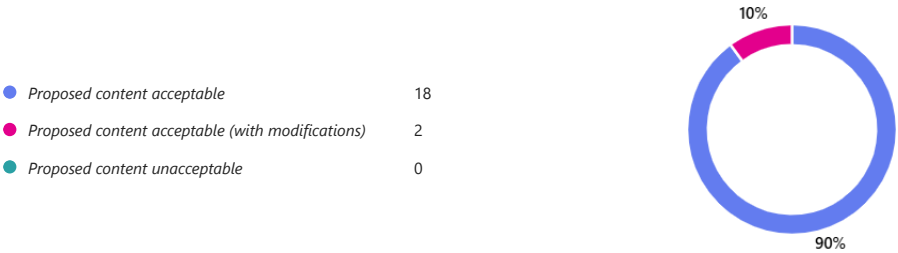
Updated content adopted from Laboratory Testing guidelines - <https://www.hpsc.ie/a-z/vaccinepreventable/measles/guidance/Laboratory%20Investigation%20of%20Measles%20Infection.pdf>.

Refer to Working draft Section 2.1.1 Testing of index case to review updated content.



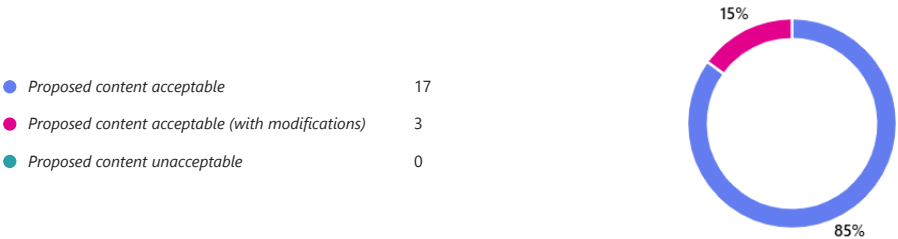
3. **NEW Content**
Section 2.1.2 Risk Assessment
Replace figure 3 (illustrating the principles of risk assessment and public health management) with algorithm (figure illustrating risk assessment, indications for testing and which test to use).

Refer to Working draft Section 2.1.2 Risk Assessment to review new content.



4. **NEW Content**
Section 2.1.3 Exclusion of the index case
Add following sentence: "More information on Immunosupressed individuals is available in NIAC Immunisation Guidelines: Chapter 3 and d 12 available at Royal College of Physicians of Ireland Website > Healthcare Leadership > NIAC > Immunisation Guidelines for Ireland ([rcpi.ie](#))".

Refer to Working draft Section 2.1.3 Exclusion of the index case to review new content.



5. Updated content

Section 2.2.2 Defining exposure risk

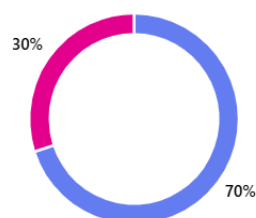
Updated content adopted from NIAC guidelines on defining exposure risk for *Vulnerable immunocompetent individuals (infants, pregnant women)*.

Current UKHSA content: For immunocompetent vulnerable individuals (infants, pregnant women), local HPTs should prioritise contact tracing efforts to those most likely to have had close or prolonged exposure to a primary measles infection. If the index case is presumed breakthrough measles (reinfection), individuals in this group do not need to be identified and assessed. Contact tracing should focus primarily on: • close contacts including household contact • face to face contact of any length • more than 15 minutes in a small, confined area, for example room in a house, classroom, 4-bed hospital bay (including healthcare workers)

Updated content to reflect NIAC guidelines: NIAC Guidance describes the following regarding exposure risk. Exposure to measles is considered significant if a susceptible individual is exposed to a confirmed or probable case of measles during the infectious period (four days before to four days after rash onset) in any of the following ways: • Face-to-face contact of any duration. • An immunocompetent individual is in a room with the case for more than 15 minutes. This includes those who, within the preceding six days, may have been exposed to measles in the setting of an emergency department or an outpatient clinic where the intensity of such exposure cannot accurately be judged.

Refer to Working draft Section 2.2.2 Defining exposure risk to review updated content.

● Proposed content acceptable	14
● Proposed content acceptable (with modifications)	6
● Proposed content unacceptable	0



6. NEW content

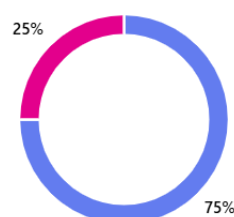
Section 2.2.2 Defining exposure risk

New content adopted from NIAC guidelines on defining exposure risk for *Vulnerable immunocompetent individuals (infants, pregnant women)*.

Include the following sentence; "As mentioned above, for immunocompetent individuals, significant exposure is defined as being in a room with the case for more than 15 minutes. This includes those who, within the preceding six days, may have been exposed to measles in the setting of an emergency department".

Refer to Working draft Section 2.2.2 Defining exposure risk to review updated content.

● Proposed content acceptable	15
● Proposed content acceptable (with modifications)	5
● Proposed content unacceptable	0



7. NEW content**2.2.3.1 Immunosuppressed patients - assess risk and susceptibility**

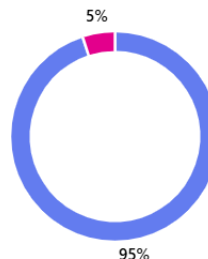
Add the following sentence; "These individuals can be divided into 2 main groups (Table A), depending on their ability to maintain adequate antibody from past exposure or vaccination".

Also include Table A.

New content adopted from NIAC and UKHSA guidelines.

Refer to Working draft 2.2.3.1 *Immunosuppressed patients - assess risk and susceptibility* to review updated content.

● Proposed content acceptable	19
● Proposed content acceptable (with modifications)	1
● Proposed content unacceptable	0

**8. UPDATED content****2.2.3.1 Immunosuppressed patients - assess risk and susceptibility**

Current UKHSA content Group B includes individuals who are unlikely to have developed or maintained adequate antibody levels from past exposure or vaccination. This group can be further subdivided into: • B (i) individuals who can be managed based on a measles IgG test at the time of exposure or at any point since the end of treatment or diagnosis • B (ii) individuals who require IVIG following an exposure without the need for testing.

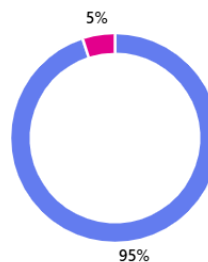
Updated content to reflect NIAC guidelines

Group B includes individuals who are severely immunosuppressed and may not have developed or maintained adequate antibody levels from past exposure or vaccination.

This group can be further subdivided into: • B (i) individuals who can be managed based on a measles IgG test urgently requested following exposure or at any point since the end of immunosuppressive treatment or diagnosis regardless of past vaccination history or previous serologic test result. B (ii) individuals who require IVIG following an exposure without the need for testing and regardless of immunologic or vaccination status.

Refer to Working draft 2.2.3.1 *Immunosuppressed patients - assess risk and susceptibility (Group B)* to review updated content.

● Proposed content acceptable	19
● Proposed content acceptable (with modifications)	1
● Proposed content unacceptable	0



9. **UPDATED content**

2.2.3.2 Management of immunosuppressed contacts

Current UKHSA guidance:

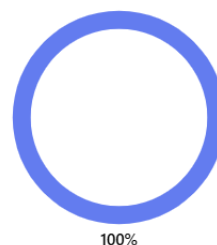
"For patients in group B (i) who have a documented positive measles IgG since diagnosis or treatment end, no IVIG is required. For all others in group B (i), urgent IgG testing should be conducted at the time of exposure".

Updated content to reflect NIAC guidelines as follows;

"For patients in group B (i) urgent IgG testing should be conducted at the time of exposure, regardless of past vaccination history or previous serologic test result. If measles IgG is detected, post exposure prophylaxis is not required. If seronegative, offer post exposure prophylaxis".

Refer to Working draft 2.2.3.2 Management of immunosuppressed contacts to review updated content.

● Proposed content acceptable	20
● Proposed content acceptable (with modifications)	0
● Proposed content unacceptable	0

10. **UPDATED content**

2.2.3.2 Management of immunosuppressed contacts

Current UKHSA guidance

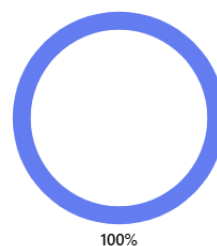
"For immunosuppressed patients where exposure is recognised late or who are found to be antibody negative or equivocal between 6 and 18 days after exposure, discussion with the specialist caring for the individual should take place, and IVIG may be considered in order to attenuate infection".

Updated content

"For immunosuppressed patients where exposure is recognised late or who are found to be antibody negative or equivocal more than 6 days after exposure, discussion with the specialist caring for the individual should take place, and IVIG may be considered in order to attenuate infection".

Refer to Working draft 2.2.3.2 Management of immunosuppressed contacts to review updated content.

● Proposed content acceptable	20
● Proposed content acceptable (with modifications)	0
● Proposed content unacceptable	0

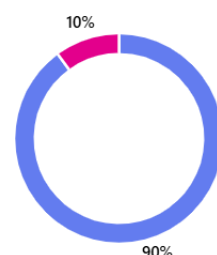
11. **NEW content**

2.2.3.2 Management of immunosuppressed contacts

Table 3: Assessing evidence of protection in immunosuppressed contacts of measles - replace with New Table 3a and 3b created for Irish context as per NIAC guidelines.

Refer to Working draft 2.2.3.2 Management of immunosuppressed contacts to review updated content Table 3.

● Proposed content acceptable	18
● Proposed content acceptable (with modifications)	2
● Proposed content unacceptable	0



12. **NEW content**

2.2.4 Immunocompetent vulnerable contacts: pregnant women - Assessing susceptibility for Irish context

Current UKHSA guidance

"Seroprevalence studies have shown that less than 1% of individuals born before 1970 and less than 10% born between 1970 and 1989 are antibody negative to measles. The low susceptibility is confirmed by few cases being confirmed in these age groups (data collated by UKHSA Immunisation and VPD Division at Colindale). Younger adults may have been naturally infected or vaccinated as children, with those born after 1978 being eligible for a second dose of measles-containing vaccine during the 1994 schools campaign.Therefore, in older women (born before 1990) with a reliable history of measles infection, antibody testing is unnecessary and should be avoided.

Individuals born after 1990 are unlikely to have been exposed to natural measles and will mainly have acquired immunity through vaccination. Around 90% of individuals respond to a single dose of measles-containing vaccine and around 95% will be protected following 2 doses".

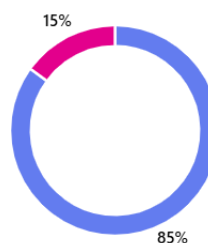
Updated content

"An Irish seroprevalence study showed that 95% of children aged 11-14 years, attending Paediatric outpatients in Dublin in 1991-1992 had antibodies to measles. Younger adults may have been naturally infected or vaccinated with a single dose of a measles – containing vaccine as children from 1985, with those aged 10-14 years in 1992 eligible for a second dose of measles-containing vaccine".

Ref: Johnson H, Hillary IB, McQuoid G, Gilmer BA. MMR vaccination, measles epidemiology and sero-surveillance in the Republic of Ireland. Vaccine. 1995 Apr;13(6):533-7. doi: 10.1016/0264-410x(94)00021-e. PMID: 7483773

Refer to Working draft Section 2.2.4 Immunocompetent vulnerable contacts: pregnant women

● Proposed content acceptable	17
● Proposed content acceptable (with modifications)	3
● Proposed content unacceptable	0

13. **UPDATE content**

2.2.4.2 Management of pregnant contacts

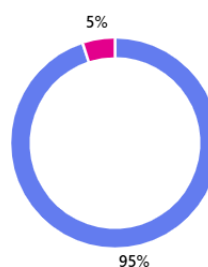
Update management of pregnant contacts in Irish context. Table 4 replaced by text from NIAC as follows:

NIAC recommendation

"HNIG should be administered to pregnant women without evidence of measles immunity who have had significant exposure to measles. Ideally it should be given within three days of exposure but can be given up to six days, allowing time for assessment of immunity status in most instances. Women with measles IgG titres reported as 'positive' or 'weak positive' are likely to have measles vaccine or infection induced immunity and do not need HNIG".

Refer to Working draft Section 2.2.4.2 Management of pregnant contacts

● Proposed content acceptable	19
● Proposed content acceptable (with modifications)	1
● Proposed content unacceptable	0



14. **UPDATED content***2.2.5 Immunocompetent vulnerable contacts: infants***Current UKHSA content**

"All infants under 6 months old who have a significant exposure to measles should get HNIG due to the high likelihood of maternal antibodies interfering with the response to MMR vaccine".

Updated content

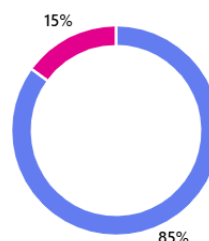
Replace with: Infants aged < 6 months for Irish context as per NIAC guidelines.

"All infants under 6 months old who have a household or household type exposure to measles should get HNIG, ideally within 3 days of exposure and can be given with potential benefit up to 6 days.

For non household exposure if the infant's and mothers measles IgG status can be ascertained within three days of exposure and is positive, HNIG is not indicated. If the measles IgG result is weakly positive, equivocal, negative or unknown, HNIG is recommended, and should be given within three days. It can be given with potential benefit up to six days following exposure".

Refer to Working draft 2.2.5 *Immunocompetent vulnerable contacts: infants (Infants aged <6 months)*

● Proposed content acceptable	17
● Proposed content acceptable (with modifications)	3
● Proposed content unacceptable	0

15. **UPDATED content***2.2.5 Immunocompetent vulnerable contacts: infants***Current UKHSA content**

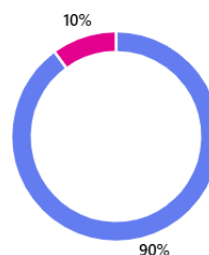
"Infants aged 6 to 8 months who are household contacts of a case and therefore have a higher intensity exposure should be given HNIG due to the increased risk of more severe disease. Infants aged 6 to 8 months who have exposures in non-household settings are less likely to have the intensity of exposure to develop severe disease and so should receive MMR vaccine. Infants aged 9 months or older should receive MMR vaccine as response to MMR is improved at this age. Vaccine is also preferred in non household settings as it may protect against a tertiary wave of cases in that setting".

Update Replace with: Infants aged 6-8 months for Irish context as per NIAC guidelines.

"Infants aged 6-8 months: Infants aged 6 to 8 months who have household or household type exposure, give the MMR vaccine if the exposure was within the preceding 3 days. If the exposure is between 3 and 6 days previously and MMR vaccine has not been given within 3 days of exposure, give HNIG if feasible. Infants aged 6 to 8 months who have exposures in non-household settings are less likely to have the intensity of exposure to develop severe disease and so should receive MMR vaccine within three days of exposure. If MMR vaccine cannot be given within three days of exposure, HNIG should be considered up to six days".

Refer to Working draft 2.2.5 *Immunocompetent vulnerable contacts: infants (infants aged 6-8 months)*

● Proposed content acceptable	18
● Proposed content acceptable (with modifications)	2
● Proposed content unacceptable	0



16. **UPDATED content**

2.2.5 Immunocompetent vulnerable contacts: infants Table 5 Assessment and Treatment of infants

Update Replace Table 5 Assessment and Treatment of infants with slightly amended Irish version based on NIAC guidance. Refer to Working draft 2.2.5 Immunocompetent vulnerable contacts: infants, Table 5

● Proposed content acceptable	18
● Proposed content acceptable (with modifications)	2
● Proposed content unacceptable	0

17. **UPDATED content**

2.3 Dosage and administration of immunoglobulin - What is the dose of PEP IG and how should it be administered in Irish context?

Current UKHSA guidance

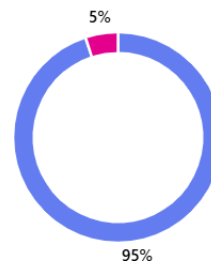
"Public Health England (PHE) performed plaque neutralisation testing many of the currently available immunoglobulin products manufactured by BPL and Baxalta and has received similar data from CSL Behring. Based on these results and applying the protective per/kg dose established by Endo and others (31), the doses of intramuscular HNIG recommended in the past are not fully protective (9), and therefore a fully protective dose cannot be realistically achieved using an intra-muscular injection (see Annexe 3 for more information). The following recommendations are therefore made allowing for the lowest levels of neutralising measles antibody observed in products available in the UK".

Updated content:

"Although not all HNIG products are licensed for post exposure prophylaxis, their use has proven effective in preventing or attenuating measles if given within six days of exposure" (as per NIAC guidance).

Refer to Working draft 2.3 Dosage and administration of immunoglobulin

● Proposed content acceptable	19
● Proposed content acceptable (with modifications)	1
● Proposed content unacceptable	0

18. **UPDATED content**

2.3.1 Immunosuppressed patients

Current UKHSA guidance

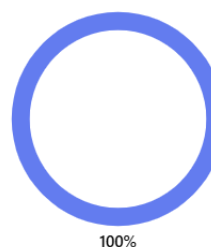
"This is available through NHS hospital pharmacies and not from UKHSA stockholders. This would constitute a grey indication in the current National Demand Management plan".

Updated content

"A number of IVIG products (Kiovig, Flebogamma, Intratect) are available through hospital pharmacies" (as per NIAC guidance).

Refer to Working draft 2.3.1 Immunosuppressed patients

● Proposed content acceptable	20
● Proposed content acceptable (with modifications)	0
● Proposed content unacceptable	0



19. **NEW content**
2.3.2 Immunocompetent patients

Suggest including the following as per NIAC guidelines;
"Dose recommendations for post-exposure prophylaxis against Measles are not well established. See NIAC guidance at <https://www.rcpi.ie/Healthcare-Leadership/NIAC/Immunisation-Guidelines-for-Ireland> for information on appropriate dose, administration and adverse effects. Note Intramuscular route may be used if SC or IV administration is not practicable".

Refer to Working draft 2.3.2 *Immunocompetent patients*

