From: "Lett, Susan" <Susan.Lett@state.ma.us>, on 5/14/01 9:04 PM:

I filled-in for Matt Cartter and represented CSTE at the ACIP Work Group Meeting in Atlanta on May 9 -10 , 2001. The purpose of the meeting was to discuss issues relevant to recommendations for the live attenuated influenza vaccine (LAIV).

Additional data was presented that supplements the published data demonstrating that influenza causes substantial morbidity in children. Influenza in children is often unrecognized because it has an even more nonspecific presentation than in adults. These include GI symptoms, wheezing, sepsis syndrome and febrile rash illness. New data will soon be published by Dr. Kathy Neuzil showing that previous estimates may have under-represented the disease burden in young age groups.

There is very little chance that the cold adapted (ca) reassortant virus will revert to wild type virus. It is also unlikely to very transmissible. However, that potential exists and may affect recommendations for the household contacts of immunocompromised children (although there was a difference of opnion among the experts.)

There is a paucity of data about the administration of LAIV and TIV (trivalent inactivated influenza vaccine) in very young children (e.g., 6-35 months), where the morbidity is highest. TIV is only licensed for use in children 6 months of age and older. The application for LAIV is for use in individuals 1 - 64 years of age.

There is a lack of data on the use of LAIV in children with high risk conditions, particularly immunosupression. There is also not enough safety and immunogenicity data on the simultaneous administration of LAIV with other childhood vaccines. Another interesting question would be to look at whether the immunogenicity of the ca influenza virus is decreased in kids who had fevers within 48 hours immunization.

Some of this missing information can be obtained by a re-analysis of the existing clinical studies, some can be obtained from the Vaccine Safety Datalink projects and some would require new studies. After it is determined how many questions can be answered from existing data, the ACIP will prioritize the research questions when they meet in June. It is thought that ACIP might issue recommendations for LAIV in the fall of 2001.

There were several issues raised that are relevant specifically for state health departments:
- LAIV is a frozen virus that will have to be shipped on dry ice similar to varicella vaccine and is expected to be very sensitive to the cold chain. . This could pose logistical problems for states, particularly if using LAIV in large-scale public clinic settings. When fully deployed and used in the average provider's office this could also result in decreased vaccine efficacy.

- ACIP has to decide how broad the age range for the recommendations for LAIV should be, e.g., 1 - 64 years or priorize to younger age groups. It also needs to decide how strongly any recommendation for either TIV or LAIV should be for children, taking consideration the cost and availability of vaccine and the lack of any new combination vaccines on the immediate horizon.

- After LAIV is licensed, there will still be many people for whom it will be contraindicated because of age or lack of data on efficacy and safety. TIV will still need to be ordered and distributed by state health departments for these groups. The difference in the cost of the 2 vaccines will also affect many states abilities to provide LAIV.

- Timing of any ACIP recommendations should take into consideration the licensure and availability of adequate supplies of LAIV in relation to the flu season, e.g., if LAIV were to be licensed some time in the late fall and early winter during the 2001-2002 flu season, new recommendations should not be effective until the 2003-2004 season. This way providers and manufacturers have enough time to plan and prepare.

Myself and others urged ACIP to consider these practical issues for states when formulating any recommendations.

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