

Immunization Action

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Larry Pickering, MD
Executive Secretary
Advisory Committee on Immunization Practices (ACIP)
National Immunization Program/Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333

Dear Dr. Pickering and ACIP members:

I am writing to urge that ACIP adopt a recommendation for universal hepatitis B vaccination of adults through the age of 49 years. By way of background, I am the executive director of the Immunization Action Coalition (formerly known as the Hepatitis B Coalition), chair of the National Viral Hepatitis Roundtable (a coalition of more than 120 organizations working to eliminate viral hepatitis in the United States), and a consultant to the Hepatitis Working Group.

My purpose is to make sure that ACIP members are aware of their historic opportunity to make a remarkable improvement in the health of U.S. adults by recommending an age-based hepatitis B vaccination strategy. An age-based strategy is necessary in order to protect individuals who are not served by the current risk-based approach.

Here are some "headlines" that I think summarize the argument for making an age-based vaccination recommendation for preventing HBV infection.

Age-based recommendations are more effective than risk-based recommendations.

Recommendations for universal vaccination of infants and children have achieved remarkable levels in just over a decade. By the year 2000, more than 90% of children ages 19-35 months were vaccinated against hepatitis B as were 67% of adolescents ages 13-15 years¹. In the U.S., we have had a recommendation to vaccinate men who have sex with men (MSM) since the early 1980s. Similarly we have had recommendations to vaccinate STD clients and incarcerated persons since the early 1990s. In spite of these risk-based vaccination recommendations, these risk groups are woefully undervaccinated.

Fairness dictates that currently unprotected adults be given the opportunity to be vaccinated against hepatitis B.

The current population of unprotected adults, including many at high risk, should not be denied the opportunity to avoid this debilitating and life-threatening disease.

There are insurmountable obstacles to screening patients for hepatitis B risk factors in primary care settings.

- Physicians don't have enough time to take hepatitis B risk histories on all their adult patients. Discussing sensitive lifestyle issues (e.g., sexual preferences and practices, needle use, and other drug use) and reviewing 10 screening questions with one's patients are not possible within the time allotted for a visit to the physician's office.
- Physicians are reluctant to take sex histories. Taking a sex history can open a Pandora's box of sensitive personal issues. Taking a sex history requires training as well as a willingness and commitment to help patients work through the complex and delicate issues that arise.

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- Many patients do not want to disclose “stigmatizing” activity that would place them in a risk group.
- Generally, patients do not want their risk behaviors recorded in their medical records, especially in light of the possible use of those records by insurance companies.

Insurance companies are more likely to cover the cost of hepatitis B vaccine when there is a clear ACIP recommendation for routine use of the vaccine.

Experience has shown this to be the case for almost all other routinely recommended vaccines for children and adults.

Routinely vaccinating adults against HBV infection will be needed only for a limited period.

This “catch-up” program will be needed only for the period of time necessary to vaccinate those adults who have not yet benefited from child and adolescent vaccination programs. Therefore, there will be neither long-term nor ongoing costs for this program. It is also important to note that if a recommendation for routine adult vaccination is to be made, it should be made now rather than later in order to maximize vaccination coverage of our unprotected aging adult population.

An ACIP recommendation to routinely vaccinate adults will enable advocate organizations to successfully lobby Congress for increased public funding for HBV prevention.

Without such an ACIP recommendation, little support can be generated by immunization advocacy organizations for increased public funding of hepatitis B prevention activities.

I am hopeful that ACIP will seize this critical opportunity to *truly* “eliminate [hepatitis B virus] transmission in the United States.”

With warm regards,

Deborah L. Wexler, MD
Executive Director

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¹ CDC. Achievements in Public Health: Hepatitis B Vaccination – United States, 1982-2003. *MMWR* 2002;51:549-552,562.