



Italian Terrace

PIC QUESTION OF THE WEEK: 1/16/12

Q: What are the current recommendations for the administration of meningococcal vaccine?

A: Meningococcal diseases are the result of infection by the aerobic, gram negative bacterium known as *Neisseria meningitidis*. The organism is classified in a variety of serogroups (A, B, C, Y and W-135) based on the nature of the polysaccharide capsule. Common meningococcal diseases include meningitis, septicemia, pneumonia, arthritis, otitis media and epiglottitis. Unfortunately, neither the original polysaccharide vaccine (Menomune) or more recent conjugate preparations (Menactra and Menveo) prevents disease associated with serogroup B. Since publication of the CDC's Advisory Committee on Immunization Practices (ACIP) recommendation on use of meningococcal vaccine in 2005, additional data has been generated and resulted in publication of new guidelines for vaccine administration. These changes relate to designated age groups, booster doses, etc. The enclosed table provides a synopsis of some key dosing guidelines for meningococcal vaccines including the recent update for dosage in the 9 to 23 month age group. Earlier recommendations for other age groups are also presented in the table. The reader is encouraged to review the various CDC recommendations on meningococcal vaccine in the accompanying reference.

ACIP Recommendations for Administration of Meningococcal Vaccine*

Risk group	Primary Series	Booster Dose**
Children aged 9 to 23 months at increased risk [†] (without functional or anatomical asplenia)	2 doses, 3 months apart If dose 2 is not received on schedule, administer at earliest opportunity	Initial booster 3 years after primary series Booster every 5 years for those at continued increased risk
Children aged 9 to 23 months at increased risk [†] with functional or anatomical asplenia	2 doses, 2 months apart, at age 2 at least 4 weeks after completion of pneumococcal vaccine series	Initial booster 3 years after primary series Booster every 5 years for those at continued increased risk
Persons aged 11 through 18 years	1 dose, preferably at age 11 or 12 years	At 16 years if primary dose at 11 or 12 years At 16 -18 years if primary dose at 13 - 15 years No booster needed if primary dose on or after 16 years
HIV-infected persons aged 11 through 18 years	2 doses, 2 months apart	At age 16 years if primary dose at age 11 or 12 years At 16 -18 years if primary dose at age 13 - 15 years No booster needed if primary dose on or after 16 years
Persons aged 2 through 55 years with persistent complement component deficiency or functional or anatomical asplenia	2 doses, 2 months apart	Every 5 years At the earliest opportunity if a 1-dose primary series administered, then every 5 years
Persons aged 2 through 55 years with prolonged increased risk for exposure	1 dose	Persons aged 2 through 6 years: after 3 years Persons aged 7 years or older: after 5 years

* See complete dosing guidelines in the CDC reference included below. ** Booster doses should be given at a minimum interval of 8 weeks.

[†]Those with complement component deficiencies, those traveling to countries in which meningococcal disease is considered epidemic or hyperendemic, and those in a particular risk group due to an institutional or community outbreak.

References:

- Centers for Disease Control and Prevention. Meningococcal Vaccine Recommendations. <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm#mening> Accessed Jan. 12, 2012

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