DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
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FALLS CHURCH, VA 22041-3258

REPLY TO
ATTENTION OF

DASG-PPM-NC

26 August 2003

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Policy for Influenza Vaccination, 2003-2004 Season

1. The annual influenza immunization program will begin 15 October 2003. The primary goal of the program is to vaccinate all active duty personnel and selected TRICARE beneficiaries IAW guidance provided in the Enclosure.

2. Influenza vaccine will be shipped to distribution sites in phases. Defense Supply Center Philadelphia anticipates initial delivery of influenza vaccine to the depot by 30 September 2003 and that all vaccine will be received by 15 December 2003. Release of vaccine to distribution sites will occur as soon as possible after depot receipt of vaccine. Military Treatment Facilities will prioritize vaccine administration IAW guidance provided in the Enclosure. I anticipate that sufficient vaccine will be available by December to accomplish vaccination for all beneficiary populations.

3. The FDA approved FluMist®, an intranasal, live, attenuated vaccine for use in healthy people, 5-49 years of age. The policy for the influenza program does not include the use of FluMist® because of its prohibitive cost and stringent storage requirements.

4. All vaccine administrations and/or exemptions given to active and reserve component personnel will be documented in MEDPROS. Major Command, Regional Medical Command, and installation compliance with the influenza vaccination program will be monitored through this system beginning the week of 19 October 2003. Vaccinations were documented for only 72% of all soldiers in the Army and 82% of soldiers in the MEDCOM for the 2002-2003 influenza immunization program that concluded on 29 January 2003. I expect that all will achieve a "green" status (90% or greater vaccinated) NLT 23 January 2004.

5. My point of contact is COL P. K. Underwood, Proponency Office for Preventive Medicine, Office of The Surgeon General, DSN 761-3160, Commercial (703) 681-3160, or e-mail Paula.Underwood@otsg.amedd.army.mil. POC for training requirements for MEDPROS is LTC Anne Guevara at DSN 471-7124, Commercial (210) 221-7124. Questions on MEDPROS data entry may be referred to the MODS Help desk at DSN 761-4976, Commercial (703) 681-4976.

FOR THE SURGEON GENERAL:

Encl

KENNETH L. FARMER, JR., M.D.
Major General
Deputy Surgeon General

DISTRIBUTION:
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DASG-PPM-NC

2003-2004 ARMY INFLUENZA IMMUNIZATION & CONTROL PROGRAM

1. References:

a. Army Regulation 40-562, 1 November 1995, Immunizations and Chemoprophylaxis.

b. CDC Influenza Home Page (new and updated information, provider's information, supply concerns and updates, public affairs and media materials, patient education materials). http://www.cdc.gov/nip/flu

c. Morbidity and Mortality Weekly Report, Volume 52, Number RR-8, 25 April 2003, subject: Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5208a1.htm

2. Distribution: Disseminate this guidance to all preventive medicine, immunization, family practice, primary care, pharmacy, and medical logistics divisions, services, clinics, and sections, and unit/command surgeons.

3. 2003-04 Influenza Vaccine:

a. The 2003-2004 trivalent vaccine contains A/New Caledonia/20/99 (H1N1)-like, A/Moscow/10/99 (H3N2)-like, and B/Hong Kong/330/2001-like viruses.

b. National stock numbers (NSNs) for the 2003-2004 flu vaccine program are as follows: NSN: 6505-01-503-4958 Fluvirin® (split virus or purified surface antigen for persons 4 years and older) and NSN: 6505-01-504-6594 Fluzone® (split virus only for persons 6 months of age or older). Because of their decreased potential for causing febrile reactions, only split-virus vaccines should be used for children aged <13 years.

c. This year DoD has contracted for vaccine from two manufacturers (Aventis Pasteur, Inc., -33% and Evans Vaccine Ltd -67%).

d. Although federal law does not require written informed consent, the CDC has published a Vaccine Information Statement: "Influenza Vaccine - What You Need to Know – 2003-2004". This statement must be conspicuously displayed at vaccination sites and readily available to provide to each individual patient upon request. The information statement Appendix A, can be downloaded from www.cdc.gov/nip/publications/VIS/default.htm and reproduced locally.

4. Vaccine Logistics. Influenza vaccine is distributed to Medical Treatment Facilities (MTFs) through pharmacy and/or logistics activities. Information and official messages regarding the distribution of influenza vaccine may be obtained from the USAMMA website http://www.usamma.army.mil. Questions may also be referred to MAJ Patrick Garman, DSN 343-4307, Comm (301) 619-4307 or Ms. Mary Jane Carty, DSN 343-3242, Comm (301) 619-3242.

5. Priority for influenza vaccination: Appendix B is a matrix for vaccine prioritization. This matrix is consistent with guidance from the CDC (reference c). Upon receipt of influenza vaccine, MTFs will administer vaccine IAW with this list. All active duty military personnel must be vaccinated. Military personnel supporting current combat operations, high-risk beneficiaries, and health care workers are the top priority for vaccination with the first deliveries of vaccine in October. Soldiers in initial training are the next priority; MTFs at Army Training Centers should begin vaccinating new recruits by the end of October. Beneficiaries in other categories may receive vaccination in November. Full-scale campaigns to vaccinate all beneficiaries should commence not later than early December.

6. Special Considerations.

a. Trainees will be vaccinated year-round, or until the vaccine's labeled expiration date. In recent years, influenza vaccine lots have expired on June 30th.

b. Because influenza is endemic during off-season periods in the tropics and the Southern Hemisphere (winter occurs from June through August), individuals who deploy to these regions should be immunized year-round, or until the vaccine's labeled expiration date.

c. MTF Commanders should coordinate with supported component surgeons to distribute vaccine intended for operational use.

7. Contraindications:

a. Vaccine should not be administered to persons known to have anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine without first consulting a physician. Allergy to influenza vaccine should not be confused with mild systemic reactions characterized by fever, malaise, myalgia, and local redness at the injection site. These side affects are self-limiting, resolve quickly, and do not constitute an allergic reaction.

b. Persons with acute febrile illness usually should not be vaccinated until their symptoms have abated. However, minor illnesses with or without fever do not contraindicate the use of vaccine, particularly among children with mild upper respiratory tract infection or allergic rhinitis.

c. Pregnancy and Breast-feeding. Pregnant women who have medical conditions that increase their risk for complications from influenza should be vaccinated before the influenza season, regardless of the stage of pregnancy. Because of the increased risk for influenza-related complications, women who will be beyond the first trimester of pregnancy (>14 weeks of gestation) during the influenza season should be vaccinated. Influenza vaccine does not affect the safety of mothers who are breast-feeding nor their infants. Breast-feeding does not adversely affect the immune response and is not a contraindication for vaccination.

8. Side effects and adverse reactions. Soreness at the vaccination site lasting up to 2 days, fever, malaise, myalgia, and other systemic symptoms may occur. These begin 6-12 hours after vaccination and can persist for 1-2 days. Immediate allergic reactions include hives, angioedema, allergic asthma, and systemic anaphylaxis. Per AR 40-3, paragraph 11-6d(9), all known or suspected adverse events related to the administration of influenza vaccine will be

reported to the MTF Pharmacy and Therapeutics Committee for further review and consideration to forward to the Food and Drug Administration.

9. Surveillance and Case Reporting:

a. It is important to confirm that local increases in respiratory disease occurrence are caused by influenza and to identify the specific viruses involved. Results of these efforts may initiate supplementary disease control activities. MTFs should institute procedures to identify and monitor patients with influenza-like illness (ILI) and ensure that appropriate clinical specimens are collected and submitted for laboratory analysis (culture). For this purpose, ILI may be defined as fever, respiratory symptoms, sore throat, myalgia and headache with or without clinical or radiographic evidence of acute non-bacterial pneumonia. Deep rolled nasal swabs or nasopharyngeal washes should be taken from patients with ILI and from any individual with acute non-bacterial pneumonia.

b. Case Reporting. All laboratory-confirmed cases of influenza infection should be reported through preventive medicine activities to the Reportable Medical Events System (RMES) at the Army Medical Surveillance Activity (AMSA). Reported cases should meet the case definition found in the Tri-Service Reportable Events List published at http://amsa.army.mil/. POC at AMSA is LTC Arthur Baker at DSN 662-0471 or Comm (202) 782-0471.

10. Laboratory Testing Support:

a. The US Air Force continues as the executive agent for laboratory-based influenza surveillance. Sentinel sites are selected based on location, mission, and training status. Army MTFs interested in participating may contact the Air Force Institute of Environment, Safety, and Occupational Health Risk Analysis by email at influenza@brooks.af.mil for further details.

b. Army Regional Medical Centers (LRMC, WRAMC, EAMC, BAMC and TAMC) offer full clinical viral culture services for their subordinate MEDDACs. Moreover, MAMC offers a fluorescent, non-culture method for the most common respiratory pathogens. Rapid diagnostic tests for influenza can aid clinical judgment and help guide treatment decisions, particularly if anti-viral therapy is considered for treatment. Nonetheless, the use of such tests requires oversight to assure appropriate use and interpretation in the clinical setting. For more information concerning rapid diagnostic tests for influenza, contact LTC William Nauschuetz, Chief, Microbiology, Brooke Army Medical Center, at DSN: 429-0329 or Commercial (210) 916-0329.

11. Reporting Requirements for Active Duty Vaccinations:

a. The status of MACOM, Regional Medical Command and installation compliance with the requirement to vaccinate all active duty (AD) personnel will be tracked through the Medical Protection System (MEDPROS) of the Military Occupational Data System (MODS).

b. Several areas require emphasis. There must be universal implementation of procedures at installation in-and out-processing stations to ensure that personnel in PCS transition receive vaccination. SIDPERS and DEERS registry of new accessions must be accomplished to capture immunization data in the newest soldiers. Special efforts must be initiated to ensure that both vaccination and documentation efforts are extended to soldiers who serve in remote locations.

c. The medical facility or activity that provides medical support is responsible for ensuring that vaccine data is entered into MEDPROS. Data entry may be accomplished using the MEDPROS web base (www.mods.army.mil), the MODS mainframe, the Remote Immunization Data Entry System (RIDES) CD, or other systems/processes in coordination with the MODS Support Team. Data entry support may be obtained from the MODS Help Desk at DSN 761-4976, Commercial (703) 681-4976 or (888) 849-4341.

d. MEDPROS will continue to offer a command drill-down reporting capability to allow all users to track compliance. OTSG will monitor compliance rates by Major Command (MACOM), Regional Medical Command (RMC) region, and installation using MEDPROS drill-down reports. This tracking will commence during the week of 19 Oct 03. Compliance will be categorized as green (>=90% of personnel vaccinated), amber (80-90% vaccinated), and red (<80% vaccinated). The goal is for each MACOM, RMC region, and installation to achieve a green status NLT 23 Jan 04.

Appendices:

Appendix A - CDC Vaccine Information Sheet: **Influenza Vaccine: What You Need To Know 2003-2004** at http://www.cdc.gov/nip/publications/VIS/vis-flu.pdf

Appendix B - Influenza Vaccine Prioritization

INACTIVATED INFLUENZA VACCINE

WHAT YOU NEED TO KNOW

2003-2004

1 Why get vaccinated?

Influenza ("flu") is a serious disease.

It is caused by a virus that spreads from infected persons to the nose or throat of others.

Influenza can cause:

· fever · sore throat · chills
· cough · headache · muscle aches

Anyone can get influenza. Most people are ill with influenza for only a few days, but some get much sicker and may need to be hospitalized. Influenza causes an average of 36,000 deaths each year in the U.S., mostly among the elderly.

Influenza vaccine can prevent influenza.

2 Influenza vaccine

Inactivated (killed) influenza vaccine has been used in the United States for many years. Influenza viruses change often. Therefore, influenza vaccine is updated every year.

Protection develops about 2 weeks after getting the shot and may last up to a year.

Some people who get flu vaccine may still get flu, but they will usually get a milder case than those who did not get the shot.

Flu vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

3 Who should get inactivated influenza vaccine?

People 6 months of age and older at risk for getting a serious case of influenza or influenza complications, *and* people in close contact with them (including all household members) should get the vaccine.

An annual flu shot is *recommended* for:

- People **50 years of age or older.**
- Residents of **long-term care facilities** housing persons with chronic medical conditions.
- People who have **long-term health problems** with:
  - heart disease - kidney disease
  - lung disease - metabolic disease, such as diabetes
  - asthma - anemia, and other blood disorders
- People with a **weakened immune system** due to:
  - HIV/AIDS or another disease that affects the immune system
  - long-term treatment with drugs such as steroids
  - cancer treatment with x-rays or drugs
- People 6 months to 18 years of age on **long-term aspirin treatment** (these people could develop Reye Syndrome if they catch influenza).
- **Pregnant women** who will be past the 3rd month of pregnancy during the flu season (usually November - March, but past March in some years).
- Physicians, nurses, family members, or anyone else coming in **close contact with people at risk** of serious influenza

An annual flu shot is also *encouraged* for:

- **Healthy children** 6-23 months of age
- **Household contacts and out-of-home caretakers** of infants from 0-23 months of age, especially those younger than 6 months
- People who provide **essential community services**
- People at high risk for flu complications who **travel** to the Southern hemisphere between April and September, or who travel to the tropics or in organized tourist groups at any time
- People living in **dormitories** or under other crowded conditions, to prevent outbreaks
- Anyone else who wants to **reduce their chance of catching influenza**

4 When should I get influenza vaccine?

The best time to get a flu shot is in October or November.

Some people should get their flu shot in ***October*** or earlier: people **50 years of age and older**, younger people at **high risk** from flu and its complications (including **children from 6 through 23 months of age**), **household contacts** of persons at high risk, **health care workers**, and **children under 9** getting the flu shot for the first time.

To allow these people first access to the vaccine, others should wait until ***November*** to get the shot.

The flu season usually peaks between January and March, so getting the shot in ***December***, or even later, can be beneficial in most years.

Most people need only one flu shot each year to prevent influenza. Children under 9 years old getting flu vaccine *for the first time* should get 2 shots, one month apart.

5 Some people should talk with a doctor before getting influenza vaccine.

Talk with a doctor before getting a flu shot if you:

1) ever had a serious allergic reaction to **eggs** or to a **previous dose of influenza vaccine**, or
2) have a history of **Guillain-Barré Syndrome** (GBS).

If you have a fever or are severely ill at the time the shot is scheduled, you should probably wait until you recover before getting influenza vaccine. Talk to your doctor or nurse about whether to reschedule the vaccination.

6 What are the risks from inactivated influenza vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Serious problems from flu vaccine are very rare. ***The viruses in inactivated influenza vaccine have been killed, so you cannot get influenza from the vaccine.***

Mild problems:

- soreness, redness, or swelling where the shot was given
- fever
- aches

If these problems occur, they usually begin soon after the shot and last 1-2 days.

Severe problems:

- Life-threatening allergic reactions are very rare. If they do occur, it is within a few minutes to a few hours after the shot.
- In 1976, swine flu vaccine was associated with a severe paralytic illness called Guillain-Barré Syndrome (GBS). Influenza vaccines since then have not been clearly linked to GBS. However, if there *is* a risk of GBS from current influenza vaccines, it is estimated at 1 or 2 cases per million persons vaccinated . . . much less than the risk of severe influenza, which can be prevented by vaccination.

7 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your doctor, nurse, or health department to report the reaction by filing an Vaccine Adverse Event Reporting System (VAERS) form. Or call VAERS yourself at **1-800-822-7967**, or visit their website at **www.vaers.org**.

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - -Call **1-800-232-2522** (English)
  - -Call **1-800-232-0233** (Español)
  - -Visit CDC websites at **www.cdc.gov/ncidod/diseases/flu/fluvirus.htm** or **www.cdc.gov/nip**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

APPENDIX B

Influenza Vaccine Prioritization

PRIORITY

1. Operational Military Personnel

a. Personnel deployed in support of combatant command operational requirements. (e.g., Southwest Asia, Afghanistan, Korea, Eastern Europe)

b. Personnel who have orders to deploy.

2. Medically high-risk beneficiaries and their contacts

a. Persons aged 65 years on or before 1 April 2004

b. Residents of long-term care facilities

c. Adults or children with chronic disorders of the pulmonary or cardiovascular system, including asthma.

d. Adults and children with medical follow-up or hospitalization during the preceding year for:

- chronic metabolic disease, including diabetes mellitus
- renal dysfunction
- hemoglobinopathies
- immunosuppression, including medication-induced and HIV infection

e. Children (age 6 months to 18 years) on long-term aspirin therapy

f. Women who will be in the 2nd or 3rd trimester of pregnancy during influenza season.

g. Household members (age 6 months and older) of medically high-risk patients

3. Health-care workers (including civilian employees and volunteers) with direct patient contact, and employees of long-term care facilities and those who provide care to high-risk persons

4. Trainee populations, including basic and advanced trainees, officer trainees, cadets and military training cadre

5. All other active duty military personnel, including the National Guard

6. Mission-critical DoD civilians at OCONUS facilities

a. Persons between 50 and 64 years of age

b. Persons younger than 50 years of age

7. All other beneficiaries

a. Persons between 50 and 64 years of age

b. Infants age 6 months through 23 months

c. Household contacts (age 6 months and older) and out-of-home caretakers of infants (aged 0 to 23 months)

d. All other beneficiaries *

* Children < 9 receiving vaccine for the 1st time must begin in October because of the need for a booster dose in one month.