

Rubella Outbreak — Continued

In outbreaks of rubella in foreign-born populations, both prevention and control measures require a culturally sensitive approach. Collaboration between health departments and community-based organizations may be useful in effectively informing and mobilizing the at-risk population.

In recent years, rubella vaccination programs have been introduced throughout the Americas to decrease the morbidity and mortality from rubella infections during pregnancy. However, because these programs were only recently implemented, persons who have entered the United States as adults probably are not vaccinated and may be susceptible to rubella. Further decreases in rubella incidence in the United States will require increased vaccine coverage in susceptible populations.

During rubella outbreaks, vaccination is the most effective preventive measure. In the United States, two doses of MMR vaccine are recommended at age 12–15 months and 4–6 years (5). For adults who have not received rubella vaccine, a single dose of a rubella-containing vaccine is considered evidence of immunity (6). Reduction in rubella morbidity in Latin America is expected to lower the number of cases imported from this area and indigenous outbreaks in the United States.

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*Notice to Readers***Thimerosal in Vaccines: A Joint Statement
of the American Academy of Pediatrics and the Public Health Service**

The Food and Drug Administration (FDA) Modernization Act of 1997 called for FDA to review and assess the risk of all mercury-containing food and drugs. In line with this review, U.S. vaccine manufacturers responded to a December 1998 and April 1999 FDA request to provide more detailed information about the thimerosal content of their preparations that include this compound as a preservative. Thimerosal has been used as an additive to biologics and vaccines since the 1930s because it is very effective in killing bacteria used in several vaccines and in preventing bacterial contamination, particularly in opened multidose containers. Some but not all of the vaccines recommended routinely for children in the United States contain thimerosal.

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There is a significant safety margin incorporated into all the acceptable mercury exposure limits. Furthermore, there are no data or evidence of any harm caused by the level of exposure that some children may have encountered in following the existing immunization schedule. Infants and children who have received thimerosal-containing vaccines do not need to be tested for mercury exposure.

The recognition that some children could be exposed to a cumulative level of mercury over the first 6 months of life that exceeds one of the federal guidelines on methyl mercury now requires a weighing of two different types of risks when vaccinating infants. On the one hand, there is the known serious risk of diseases and deaths caused by failure to immunize our infants against vaccine-preventable infectious diseases; on the other, there is the unknown and probably much smaller risk, if any, of neurodevelopmental effects posed by exposure to thimerosal. The large risks of not vaccinating children far outweigh the unknown and probably much smaller risk, if any, of cumulative exposure to thimerosal-containing vaccines over the first 6 months of life.

Nevertheless, because any potential risk is of concern, the Public Health Service (PHS), the American Academy of Pediatrics (AAP), and vaccine manufacturers agree that thimerosal-containing vaccines should be removed as soon as possible. Similar conclusions were reached this year in a meeting attended by European regulatory agencies, European vaccine manufacturers, and FDA, which examined the use of thimerosal-containing vaccines produced or sold in European countries.

PHS and AAP are working collaboratively to assure that the replacement of thimerosal-containing vaccines takes place as expeditiously as possible while at the same time ensuring that our high vaccination coverage levels and their associated low disease levels throughout our entire childhood population are maintained.

The key actions being taken are

1. A formal request to manufacturers for a clear commitment and a plan to eliminate or reduce as expeditiously as possible the mercury content of their vaccines.
2. A review of pertinent data in a public workshop.
3. Expedited FDA review of manufacturers' supplements to their product license applications to eliminate or reduce the mercury content of a vaccine.
4. Provide information to clinicians and public health professionals to enable them to communicate effectively with parents and consumer groups.
5. Monitoring immunization practices, future immunization coverage, and vaccine-preventable disease levels.
6. Studies to better understand the risks and benefits of this safety assessment.

PHS and AAP continue to recommend that all children should be immunized against the diseases indicated in the recommended immunization schedule. Given that the risks of not vaccinating children far outweigh the unknown and much smaller risk, if any, of exposure to thimerosal-containing vaccines over the first 6 months of life, clinicians and parents are encouraged to immunize all infants even if the choice of individual vaccine products is limited for any reason.

While there is a margin of safety with existing vaccines containing thimerosal, there are steps that can be taken to increase that margin even further. Clinicians and parents can take advantage of the flexibility within the existing schedule for infants born to hepatitis B surface antigen (HBsAg)-negative women to postpone the first

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dose of hepatitis B vaccine from birth until 2 to 6 months of age when the infant is considerably larger. Preterm infants born to HBsAg-negative mothers should similarly receive hepatitis B vaccine, but ideally not until they reach term gestational age and a weight of at least 5.5 lbs (2.5 kg). Because of the substantial risk of disease, there is no change in the recommendations for infants of HBsAg-positive mothers or of mothers whose status is not known. Also, in populations where HBsAg screening of pregnant women is not routinely performed, vaccination of all infants at birth should be maintained, as is currently recommended. In addition to the key actions mentioned above, the PHS Advisory Committee on Immunization Practices and the AAP Committee on Infectious Diseases will be reviewing these issues and may make additional statements.

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**MORBIDITY AND MORTALITY
WEEKLY REPORT**

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**Bronchoscopy-Related Infections and Pseudoinfections —
New York, 1996 and 1998**

Bronchoscopy is a useful diagnostic technique that can be performed safely by trained specialists when the bronchoscopes in both inpatient and ambulatory-care settings are reprocessed properly to prevent transmission of infection. The New York State Department of Health received reports of three clusters of culture-positive bronchoscopy specimens obtained in 1996 and 1998 from patients at local health-care facilities. This report summarizes the results of investigations of these clusters, which indicated involvement of *Mycobacterium tuberculosis*, *M. intracellulare*, or imipenem-resistant *Pseudomonas aeruginosa*. Between patient uses, bronchoscopes had been cleaned, visually inspected, leak tested, and processed by STERIS System 1 processors (STERIS, Mentor, Ohio)*.

Cluster 1

During November–December 1996, bronchial specimens from five patients at a health-care facility yielded *M. tuberculosis* with the same restriction fragment length polymorphism (RFLP) pattern suggesting a common source. The index case-patient had tuberculosis with persistent acid-fast bacillus (AFB) smear- and culture-positive specimens. The four subsequent case-patients had no clinical evidence of tuberculosis, although one had a positive tuberculin skin test 6 weeks postbronchoscopy and was treated with isoniazid. Investigators concluded that all specimens from the four patients were contaminated but could not determine whether contamination occurred during the bronchoscopy or in the mycobacteriology laboratory. Specimens from three of the four case-patients were processed in the laboratory on the same day as the index case-patient's specimen.

The bronchoscopies were performed using three Olympus BF-P20D (Olympus America, Inc., Melville, New York) bronchoscopes, each processed in the same STERIS System 1 processor. Cultures from all three bronchoscopes, taken 5 weeks after the last case procedure, were negative. The same cleaning brushes used on all three bronchoscopes also were culture negative. Investigators identified an inconsistency between the disinfection/sterilization procedures recommended in the STERIS manual

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