Cigarette Smoking Among Adults — Continued

To reduce the prevalence of smoking among adults, public health programs should include smoking cessation interventions. Before 1999, tobacco-control programs did not specifically include cessation as a major feature, but concentrated on policy interventions and the prevention of the initiation of tobacco use. Although preventing tobacco use among adolescents is critical to the long-term success of tobacco-control goals, reductions in morbidity and mortality in the short term can only be achieved by helping current smokers quit. To assist in this process, *Smoking Cessation: Clinical Practice Guideline* includes recommendations for a multifaceted approach to treating nicotine dependence (*7*). This guideline has specific recommendations for three major target audiences: primary-care clinicians; tobacco cessation specialists and programs; and health-care administrators, insurers, and purchasers. CDC includes cessation as one of the nine core elements for tobacco control (*8*). In addition, CDC's National Tobacco Control Program includes promoting cessation among adults as one of its four goals. The other three goals are preventing smoking initiation, reducing exposure to environmental tobacco smoke, and eliminating disparities among various populations in the health effects of tobacco use.

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Recommendations Regarding the Use of Vaccines That Contain Thimerosal as a Preservative

On October 20, 1999, the Advisory Committee on Immunization Practices (ACIP) reviewed information about thimerosal in vaccines and received updates from CDC's National Immunization Program and several vaccine manufacturers on the current and anticipated availability of vaccines that do not contain thimerosal as a preservative. The review was prompted by a joint statement about thimerosal issued July 8, 1999, by the American Academy of Pediatrics (AAP) and the Public Health Service (PHS) (*1*) and a comparable statement released by the American Academy of Family Physicians (*2*). These statements followed a Congressionally mandated Food and Drug Administration (FDA) review of mercury in drugs and food, which included a reassessment of the use of thimerosal in vaccines.

Thimerosal is a mercury-containing preservative that has been used as an additive in biologics and vaccines since the 1930s because it prevents bacterial and fungal

Thimerosal — Continued

contamination, particularly in multidose containers. Given the widely acknowledged value of reducing exposure to mercury, vaccine manufacturers, FDA, and other PHS agencies are collaborating to reduce the thimerosal content of vaccines or to replace them with formulations that do not contain thimerosal as a preservative as soon as possible without causing unnecessary disruptions in the vaccination system. FDA will expedite review of supplements to manufacturers' product license applications that present formulations for eliminating or reducing the mercury content of vaccines.

Hepatitis B, DTaP, and Hib Vaccines

A single-antigen, preservative-free hepatitis B vaccine (Recombivax HB®, Merck & Co., Inc., West Point, Pennsylvania)* was licensed on August 27, 1999, and a second hepatitis B vaccine (Engerix-B®, SmithKline Beecham Biologicals, Philadelphia, Pennsylvania) that is preservative-free is under consideration for licensure (*3*). One manufacturer reported that the supply of its diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine that does not contain thimerosal as a preservative would be sufficient to meet any increased demand during the next year, and three other manufacturers are developing similar DTaP vaccines that could be licensed in the future. Multiple single-antigen *Haemophilus influenzae* type b (Hib) vaccines and the hepatitis B/Hib combination vaccine that do not contain thimerosal as a preservative are licensed, and the supply of these products is adequate to meet national needs.

The risk, if any, to infants from exposure to thimerosal is believed to be slight. The demonstrated risks for not vaccinating children far outweigh the theoretical risk for exposure to thimerosal-containing vaccines during the first 6 months of life.

Given the availability of vaccines that do not contain thimerosal as a preservative, the progress in developing such additional vaccines, and the absence of any recognized harm from exposure to thimerosal in vaccines, hepatitis B, DTaP, and Hib vaccines that contain thimerosal as a preservative can continue to be used in the routine infant schedule beginning at age 2 months along with monovalent or combination vaccines that do not contain thimerosal as a preservative.

Reported failures to vaccinate newborns at high risk for perinatal hepatitis B virus (HBV) transmission suggest that some institutions may have misinterpreted or improperly implemented the recommendations contained in the joint statement by the AAP and PHS—and subsequent clarification–to postpone hepatitis B vaccination only for newborns who are not at high risk (*1,3*). Chronic HBV infection develops in approximately 90% of infants infected at birth; among chronically infected infants, the risk for premature death from HBV-related liver cancer or cirrhosis is approximately 25% (*4*). All hospitals and pediatric care providers should ensure that newborn infants receive hepatitis B vaccine as recommended (Table 1) (*5*). If the supply of single-antigen hepatitis B vaccines that do not contain thimerosal as a preservative is limited, the priority for its use should be to vaccinate newborn infants (*3*).

Influenza Vaccine

All influenza vaccines contain thimerosal; however, ACIP recommends no changes in the influenza vaccination guidelines, including those for children and pregnant women (*6*). Evidence suggests that children with certain medical conditions (e.g., cardiopulmonary disease, including asthma) are at substantially increased risk for complications of influenza (*7,8*). During the influenza season, rates of cardiopulmonary hospitalizations for otherwise healthy women in their second or third trimester of

*Use of trade names and commercial sources is for identification only and does not imply endorsement by CDC or the U.S. Department of Health and Human Services.

Thimerosal — Continued

TABLE 1. Recommendations for hepatitis B vaccination of newborn infants with thimerosal-containing vaccines and vaccines that do not contain thimerosal as a preservative

Mother's HBsAg status at delivery	Recommendation
Positive or Unknown	Vaccinate at birth. Use vaccine that does not contain thimerosal as a preservative; if unavailable, use thimerosal-containing vaccine.
Negative	Vaccinate at birth or by age 2 months. At birth, use vaccine that does not contain thimerosal as a preservative. At 2 months of age, use either thimerosal-containing vaccine or vaccine that does not contain thimerosal as a preservative.
Negative–High-risk*	Same as "Negative" above, except thimerosal-containing vaccine can be administered at birth.

*Populations or groups that have a high risk for early childhood hepatitis B virus (HBV) transmission, including Alaska Natives, Asian-Pacific Islanders, immigrant populations from countries in which HBV is of high or intermediate endemicity, and households with persons with chronic HBV infection.

pregnancy are similar to that among persons aged ≥65 years who do not have a chronic medical illness and for whom influenza vaccination is also recommended (*9*). Pregnant women with chronic medical conditions are at higher risk and have a hospitalization rate more than two times greater than among pregnant women without other high-risk medical conditions. A substantial safety margin has been incorporated into the health guidance values for organic mercury exposure developed by the Agency for Toxic Substances and Disease Registry and other agencies (*10*). ACIP concluded that the benefits of influenza vaccine outweigh the potential risks for thimerosal.

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WEEKLY REPORT

Great American Smokeout — November 18, 1999

In 1997, approximately one fourth of U.S. adults and one third of U.S. high school students were cigarette smokers (*1,2*). Since 1977, the American Cancer Society (ACS) has sponsored the Great American Smokeout to encourage adults to stop smoking and young persons not to start. In 1998, an estimated 9 million persons participated in the Great American Smokeout community activities by either smoking less or not at all for 24 hours. Of those participants, 10% reported smoking less or not at all for 1–5 days after the event (ACS, unpublished data, 1998). This year, the Great American Smokeout on Thursday, November 18, will encourage smokers to adopt smoke-free, healthier lifestyles that continue into 2000.

The Great American Smokeout will focus on helping adults to quit smoking and on increasing young persons' awareness of the dangers of tobacco use. For the fourth consecutive year, ACS Commit to Quit program will provide adult smokers with information about methods of quitting smoking, including effective pharmacotherapies. ACS volunteers will conduct smoking-cessation and smoking-prevention activities at hospitals, work sites, schools, shopping malls, military installations, and other locations. To facilitate planning and implementation, the *1999 Guide for Great American Smokeout* activities is offered electronically for ACS volunteers and staff.

Additional information is available from ACS, telephone (800) 227-2345; CDC, telephone (800) 232-1311 or (770) 488-5705; or the ACS Great American Smokeout World-Wide Web site, http://www.cancer.org.*

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