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# Recommendations of the Immunization Practices Advisory Committee (ACIP) Immunization of Children Infected With Human Immunodeficiency Virus -- Supplementary ACIP Statement

The Immunization Practices Advisory Committee (ACIP) recently reviewed data both on the risks and benefits of immunizing children infected with human immunodeficiency virus (HIV) (1) and on severe and fatal measles in HIV-infected children in the United States (2). Since this review, the committee has revised its previous recommendations for measles vaccination and for mumps and rubella vaccination.

Previously published ACIP statements on immunizing HIV-infected children have recommended vaccinating children with asymptomatic HIV infection, but not those with symptomatic HIV infection (3). After considering reports of severe measles in symptomatic HIV-infected children, and in the absence of reports of serious or unusual adverse effects of measles, mumps, and rubella (MMR) vaccination in limited studies of symptomatic patients (4,5), the committee feels that administration of MMR vaccine should be considered for all HIV-infected children, regardless of symptoms. This approach is consistent with the World Health Organization's recommendation for measles vaccination (6).

If the decision to vaccinate is made, symptomatic HIV-infected children should receive MMR vaccine at 15 months, the age currently recommended for vaccination of children without HIV infection and for those with asymptomatic HIV infection. When there is an increased risk of exposure to measles, such as during an outbreak, these children should receive vaccine at younger ages. At such times, infants 6 to 11 months of age should receive monovalent measles vaccine and should be revaccinated with MMR at 12 months of age or older. Children 12-14 months of age should receive MMR and do not need revaccination (7).

The use of high-dose intravenous immune globulin (IGIV) (approximately 5 gm% protein) administered at regular intervals is being studied to determine whether it will prevent a variety of infections in HIV-infected children. It should be recognized that MMR vaccine may be ineffective if administered to a child who has received IGIV during the preceding 3 months.

Immune globulin (IG) (16.5 gm% protein) can be used to prevent or modify measles infection in HIV-infected children if administered within 6 days of exposure. IG is indicated for measles-susceptible* household contacts of children with asymptomatic HIV infection, particularly for those under 1 year of age and for measles-susceptible pregnant women. The recommended dose is 0.25 mL/kg intramuscularly (maximum dose, 15 mL)

(7).

In contrast, exposed symptomatic HIV-infected patients should receive IG prophylaxis regardless of vaccination status. The standard postexposure measles prophylaxis regimen for such patients is 0.5 mL/kg of IG intramuscularly (maximum dose, 15 mL) (7). This regimen corresponds to a dose of protein of approximately 82.5 mg/kg (maximum dose, 2,475 mg). Intramuscular IG may not be necessary if a patient with HIV infection is receiving 100-400 mg/kg IGIV at regular intervals and received the last dose within 3 weeks of exposure to measles. Based on the amount of protein that can be administered, high-dose IGIV may be as effective as IG given intramuscularly. However, no data exist on the efficacy of IGIV administered postexposure in preventing measles.

Although postexposure administration of globulins to symptomatic HIV-infected patients is recommended regardless of measles vaccine status, vaccination prior to exposure is desirable. Measles exposures are often unrecognized, and postexposure prophylaxis is not always possible.

While recommendations for MMR vaccine have changed, those for other vaccines have not (3). A summary of the current ACIP recommendations for HIV-infected persons follows (Table 1). These recommendations apply to adolescents and adults with HIV infection as well as to HIV-infected children. References

1. von Reyn CF, Clements CJ, Mann JM. Human immunodeficiency virus infection and routine childhood immunisation. Lancet 1987;2:669-72.

2. Centers for Disease Control. Measles in HIV-infected children--United States. MMWR 1988;37:183-186.

3. Immunization Practices Advisory Committee. Immunization of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1986:35: 595-8,603-6.

4. McLaughlin P, Thomas PA, Onorato I, et al. Use of live virus vaccines in HIV-infected children: a retrospective survey. Pediatrics (in press).

5. Krasinski K, Borkowsky W, Krugman S. Antibody following measles immunization in children infected with human T-cell lymphotropic virus-type III/lymphadenopathy associated virus (HTLV-III/LAV) (Abstract). In: Program and abstracts of the International Conference on Acquired Immunodeficiency Syndrome, Paris, France, June 23-25, 1986.

6. Global Advisory Group, World Health Organization. Expanded programme on immunization. Wkly Epidem Rec 1987;62:5-9.

7. Immunization Practices Advisory Committee. Measles prevention. MMWR 1987;36: 409-18,423-5.
*Persons who are unvaccinated or do not have laboratory evidence or physician documentation of previous measles disease (7).



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