Practice Point

Vaccine recommendations for children and youth for the 2016/2017 influenza season

Dorothy L Moore; Canadian Paediatric Society, Infectious Diseases and Immunization Committee

Posted: Nov 1 2016

Abstract
The Canadian Paediatric Society continues to encourage an annual influenza vaccination for ALL children and youth ≥6 months of age. Recommendations from the National Advisory Committee on Immunization for the 2016/2017 influenza season include the following changes:

1. There is no longer a preference for the use of live attenuated influenza vaccine (LAIV) over inactivated influenza vaccine in children. Either type of vaccine may be used.
2. LAIV failure reported by the U.S. Flu Vaccine Effectiveness Network has not been observed in other studies in the United States and elsewhere. NACI continues to recommend LAIV as an option.
3. Egg allergy is no longer a contraindication to receiving LAIV.

Key Words: Children; Influenza vaccine; Inactivated influenza vaccine; LAIV

Paediatricians and other health care providers caring for children and youth have important roles in promoting influenza vaccination. They can increase the uptake of influenza vaccine by helping families to recognize both the potential severity of influenza infection, and the efficacy and safety of vaccination.

Who should be vaccinated?
The Canadian Paediatric Society encourages annual influenza vaccinations for ALL children and youth ≥6 months of age, with a particular focus on individuals at high risk for influenza-related complications and people – including paediatricians and other health care providers – capable of transmitting influenza to those at high risk (Box 1). All children <5 years of age are considered to be at high risk for infection and, in addition, are efficient transmitters of influenza.[1][2]

The present practice point updates previous recommendations for the use of the influenza vaccine in children to reflect the most recent recommendations from the National Advisory Committee on Immunization (NACI).[2][4] Beginning in the 2014/15 season, NACI recommended the vaccine for all individuals ≥6 months of age, with a particular focus on people at high risk for influenza-related complications or hospitalization, and individuals capable of transmitting influenza to those at high risk. Since the 2015/16 season, children and adolescents with neurological or neurodevelopmental disorders have been added to the list of individuals considered to be high risk, based on evidence in Canada demonstrating a high burden of influenza illness in this group.[5] This recommendation has been extended to adults with neurological disorders in 2016-17 (Box 1).[2]

Why vaccinate annually?
Although some vaccinated individuals retain immunity from one season to the next, this is less likely when the predominant circulating strain changes; therefore, annual revaccination is recommended. A high failure rate of the influenza vaccine was observed during the 2014/15 season because of the appearance of an important antigenic change in the predominant circulating A H3N2 strain, rendering that component of the vaccine ineffective. The influenza A H3N2 component and one influenza B component were replaced in 2015/16. For the 2016/17 season, there
has again been a replacement of the H3N2 component and one of the B components.[6]

**What vaccine should be used?**

For several decades, influenza vaccines contained two subtypes of influenza A and one lineage of influenza B. Two lineages of influenza B have been in circulation simultaneously in recent years, and trivalent vaccines are now being replaced by quadrivalent vaccines containing two strains of influenza A and two strains of influenza B. The NACI recommends preferential use of quadrivalent vaccines for children and adolescents because influenza B causes more mortality and morbidity in children than in adults.[2]

Two types of influenza vaccines are available in Canada: inactivated influenza vaccines (IIV) for intramuscular injection and an intranasal, live attenuated influenza vaccine (LAIV).

IIV is available in quadrivalent (QIV) and trivalent (TIV) forms. An adjuvanted TIV (Fluad Pediatric, Novartis Pharmaceuticals, Canada) was recently licensed in Canada for children six to 23 months of age, and may be used for this age group when QIV is not available. While adjuvants are designed to enhance vaccine immunogenicity, there is insufficient evidence at the present time to make a preferential recommendation for adjuvanted or unadjuvanted TIV.

LAIV is now available only in the quadrivalent form. It is authorized for use in individuals two to 59 years of age.[2] LAIV is not licensed for use in children <2 years of age because of a small, but significant, increased rate of wheezing two to four weeks following vaccination observed in this age group. LAIV can be used for children and youth, two to 17 years of age, who are not immunocompromised. In previous NACI statements, LAIV was preferred over IIV for children because early studies had shown LAIV to have greater efficacy than IIV.[2] However, more recent studies have not consistently shown LAIV to provide better protection than IIV. For the 2016/17 season, the NACI does not recommend LAIV preferentially for children; either LAIV or IIV may be used.[3]

In adults, there is some evidence that IIV may be more efficacious than LAIV. Either IIV or LAIV may be used for healthy adults, but adults with chronic health conditions should receive IIV. The most common side effects of LAIV are transient nasal congestion and rhinorrhea. Reduced effectiveness of LAIV was observed in the United States during the 2013/14 influenza season. Studies indicated reduced heat stability of the H1N1 component. Failure was likely due to consequent virus degradation when the vaccine was exposed to excessive temperatures during transport or storage. A similar problem was not observed in Canada. This strain was replaced with a more heat-stable strain.[2] However, for the past three seasons, data from the U.S. Flu Vaccine Effectiveness Network (USFVEN) have shown no protective effect of LAIV against the dominant circulating strains of influenza, prompting the American Advisory Committee on Immunization Practices to recommend that for 2016/17, LAIV not be used.

In contrast to the USFVEN results, LAIV was found to be effective in 2015/16 in two other U.S. studies as well as in the United Kingdom and Finland, where LAIV will continue to be used. Therefore, the NACI continues to recommend that LAIV may be used in children. The reasons for these discordant results are currently unknown, and the NACI recognizes the need to continue to monitor LAIV effectiveness data.[3]

In summary, quadrivalent influenza vaccine is recommended for all children. For non-immunocompromised children two years of age or older, either IIV or LAIV may be used. See Table 1 for vaccine options and NACI preferences for children and youth. It is recognized that programmatic considerations may affect vaccine availability in publicly funded programs.

**When to vaccinate**

For maximum benefit, influenza vaccine should be given as soon as it is available, before the onset of the influenza season. Nevertheless, it should be offered to individuals who have not received it earlier up until the end of the current season. Benefit may be less if exposure to influenza has already occurred.

**Are there any contraindications to influenza vaccine?**

An anaphylactic reaction to a previous dose of influenza vaccine or to any of the components of the vaccine with the exception of egg, or onset of Guillain-Barre syndrome within six weeks of influenza vaccination, are contraindications to further doses.[2]

Since 2011/12, having an egg allergy has not been a contraindication to the use of IIV, but did contraindicate the use of LAIV due to lack of data. Now, however,
several studies have shown that LAIV can be given safely to egg-allergic individuals and the NACI no longer considers this condition a contraindication. Either IIV or LAIV can be given to individuals with egg allergy. Like all other vaccines, influenza vaccine should be given in a setting where anaphylaxis can be managed.

LAIV, because it is a live vaccine, is contraindicated in individuals with immune-compromising conditions. LAIV is also contraindicated for individuals with severe asthma (defined as active wheezing, currently on oral or high-dose inhaled glucocortico-steroids or medically attended wheezing within the previous seven days) and during pregnancy. LAIV is also contraindicated in children and adolescents, two to 17 years of age, receiving chronic acetylsalicylic acid-containing therapy because of the association of Reye’s syndrome with acetylsalicylic acid given during influenza infection.

LAIV should not be administered until 48 h after antiviral agents active against influenza have been discontinued. If an antiviral agent must be given within two weeks after the receipt of LAIV, another dose of vaccine should be given at least 48 h after discontinuation of therapy. For individuals experiencing nasal congestion sufficient to impede the appropriate delivery of LAIV, vaccination should be deferred until the congestion has resolved or IIV should be given.

Spread of the virus from patients immunized with LAIV can occur; however, the virus is cold-adapted and, therefore, not very pathogenic. As a precaution, it is recommended that contact with severely immunocompromised patients (such as recent transplant recipients who are still in hospital) be avoided for two weeks following LAIV.

**What is the dosage?**

The dose of IIV administered intramuscularly (IM) is 0.5 mL, regardless of age, except for paediatric adjuvanted TIV, for which the dose is 0.25 mL IM. The dose of LAIV is 0.2 mL (0.1 mL administered in each nostril as an intranasal spray).

The first year that a child <9 years of age receives influenza vaccine (either IIV or LAIV), two doses at least four weeks apart are required. If a child <9 years of age has received at least one dose of any influenza vaccine in the past, only one dose is required this season. Children ≥9 years of age and adults require only one dose each year.
**TABLE 1**

Choice of influenza vaccine for selected age and risk groups*

<table>
<thead>
<tr>
<th>Age group, health profile</th>
<th>Vaccine types available</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 6–23 months of age</td>
<td>- QIV</td>
<td>QIV preferred</td>
</tr>
<tr>
<td></td>
<td>- TIV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- ATIV</td>
<td></td>
</tr>
<tr>
<td>Children 2–17 years of age: healthy or with chronic health</td>
<td>- Q-LAIV</td>
<td>A quadrivalent vaccine (Q-LAIV or QIV) preferred</td>
</tr>
<tr>
<td>conditions without immune suppression</td>
<td>- QIV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- TIV</td>
<td></td>
</tr>
<tr>
<td>Children 2–17 years of age: immune compromising conditions</td>
<td>- QIV</td>
<td>QIV preferred</td>
</tr>
<tr>
<td></td>
<td>- TIV</td>
<td>Q-LAIV contraindicated</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>- QIV</td>
<td>Q-LAIV not recommended (not studied; theoretical risk to fetus of live vaccine)</td>
</tr>
<tr>
<td></td>
<td>- TIV</td>
<td></td>
</tr>
</tbody>
</table>

* For vaccine options for adults, see reference 2.

QIV Quadrivalent inactivated influenza vaccine; TIV Trivalent inactivated influenza vaccine; Q-LAIV Quadrivalent live attenuated influenza vaccine; ATIV Adjuvanted trivalent inactivated influenza vaccine
BOX 1

National Advisory Committee on Immunization recommendations for the 2016/2017 influenza season

Influenza vaccination is particularly recommended for the following groups:

People at high risk for influenza-related complications or hospitalization:

- All children six to 59 months of age
- All children ≥6 months of age, adolescents and adults with chronic health conditions (severe enough to require regular medical follow-up or hospital care), specifically:
  - Cardiac or pulmonary disorders including bronchopulmonary dysplasia, cystic fibrosis, asthma or conditions associated with an increased risk for aspiration
  - Diabetes mellitus and other metabolic diseases
  - Renal disease
  - Anemia or hemoglobinopathy
  - Cancer or other immune-compromising conditions (due to disease or therapy)
  - Morbid obesity (body mass index ≥ 40 kg/m²)
  - Neurological or neurodevelopmental conditions*
  - Children and adolescents (six months to 18 years of age) with a chronic condition currently undergoing prolonged treatment with acetylsalicylic acid
- All Aboriginal persons
- All residents of chronic care facilities
- All pregnant women, including adolescents, in all trimesters (for their own protection and to protect their infant after birth)
- All adults ≥65 years of age

People capable of transmitting influenza to individuals at high risk, specifically:

- Household contacts (adults and children) of individuals at high risk (listed above), regardless of whether the person at risk has been immunized
- Household contacts of infants <6 months of age (these infants are at high risk but too young to receive influenza vaccine)
- Members of a household expecting a newborn during influenza season
- Individuals providing regular child care to children ≤59 months of age, regardless of whether in or out of the home
- Health care and other care providers in facilities and community settings
- Others who provide services to individuals at high risk in closed or relatively confined settings

*These include seizure disorders, febrile seizures and isolated developmental delay in children and neuromuscular, neurovascular, neurodegenerative, neurodevelopmental conditions and seizure disorders in adults, but excludes migraines and neuropsychiatric conditions without neurological abnormalities.

References

VACCINE RECOMMENDATIONS FOR CHILDREN AND YOUTH FOR THE 2016/2017 INFLUENZA SEASON


CPS INFECTIOUS DISEASES AND IMMUNIZATION COMMITTEE
Members: Natalie A Bridger MD; Shalini Desai MD; Ruth Grimes MD (Board Representative); Charles PS Hui MD (past member); Timothy Mailman MD; Joan L Robinson MD (Chair); Marina Salvadori MD (past member); Otto G Vanderkooi MD

Liaisons: Upton D Allen MBBS, Canadian Pediatric AIDS Research Group; Tobey Audcent MD, Committee to Advise on Tropical Medicine and Travel (CATMAT), Public Health Agency of Canada; Carrie Byington MD, Committee on Infectious Diseases, American Academy of Pediatrics; Fahamia Koudra MD, The College of Family Physicians of Canada; Nicole Le Saux MD, Immunization Monitoring Program, ACTive (IMPACT); Rhonda Kropp BScN MPH, Public Health Agency of Canada; Jane McDonald MD, Association of Medical Microbiology and Infectious Disease Canada; Dorothy L Moore MD, National Advisory Committee on Immunization (NACI)

Consultant: Noni E MacDonald MD

Principal author: Dorothy L Moore MD

The Canadian Paediatric Society gives permission to print single copies of this document from our website. For permission to reprint or reproduce multiple copies, please see our copyright policy.

Disclaimer: The recommendations in this position statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate. Internet addresses are current at time of publication.