From the Chief Medical Officer
Dr Michael McBride

HSS(MD)18/2014

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Your Ref:
Our Ref: HSS(MD)18/2014
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For Action:
Chief Executives, Public Health Agency/Health & Social

Care Board/HSC Trusts/NIAS
GP Medical Advisers, Health & Social Care Board
All General Practitioners and GP Locums (*for onward distribution to practice staff)*

PLEASE SEE ATTACHED FULL CIRCULATION LIST

Dear Colleague

HPV VACCINATION PROGRAMME: CHANGE IN SCHEDULE FROM THREE TO TWO DOSES

ACTION REQUIRED

Trust Chief Executives must ensure that this information is cascaded to all School Nursing leads immediately.

The HSCB must ensure that this information is cascaded to all General Practitioners immediately.

Key Messages:

- the change will come into effect from **September 2014**, at the beginning of the academic year
- the first dose can be given at any time during school year 9
- the **minimum** time between the first and second dose should be six months where the priming dose is received at less than 15 years of age
- the **maximum** time between the first and second dose is 24 months
- girls who have not had their first dose of HPV vaccine by the time they are **15 years old** should be offered the three dose schedule. This is because the antibody response in older girls is not quite as good

Introduction

1. The purpose of this letter is to provide information on forthcoming changes to the human papillomavirus (HPV) vaccine programme. The HPV vaccine was introduced in 2008 as part of the national childhood vaccination programme. It is currently routinely offered to secondary school girls aged 12 to 13 years of age in school year 9.

2. In March 2014, the Joint Committee on Vaccination and Immunisation (JCVI) revised its existing recommendation to change from **a three to a two dose schedule**. Recent research shows that antibody response to two doses in adolescent girls is as good as a three dose course in the age group where efficacy against persistent infection and pre-cancerous lesions has been demonstrated. Emerging evidence from evaluation of HPV programmes around the world has shown that the number of young people with pre-cancerous lesions is falling and protection is expected to be long term.

3. With the new schedule it is important that a minimum of 6 months is allowed between doses. The second dose should be given within 24 months, but where this does not happen the first dose should NOT be repeated, the second dose should just be given as soon as possible.

4. Girls who have started the 3 dose regime but have not completed it by September 2014, should complete the 3 dose regime, especially where the interval between the first 2 doses is less than 6 months.

5. The vaccine used for the current HPV programme is Gardasil and is suitable for the new two dose schedule.

6. School Health Teams should ensure that both HPV doses are administered in year 9 and carry out mop-up visits for those girls in years 9 or 10 who did not receive any or both of the required number of doses.

7. Girls who have not had their first dose of HPV vaccine by the time they are **15 years old** should be offered the three dose schedule. Girls who receive their first dose before their 15th birthday only require 2 doses even if the second dose is given after the 15th birthday.

8. Both Gardasil and Cervarix (the HPV vaccine used when the programme was first introduced) have been approved for use in a two dose schedule. The patient information leaflet (PIL) included in the packaging may still refer to a three dose schedule, or give different recommended timings between doses. The PIL will be updated by the vaccine manufacturer as soon as possible and issued with the vaccine being delivered from September onwards. If the updated PIL for the two dose schedule is not supplied with the vaccine it can be obtained and printed from the following link http://www.medicines.org.uk/emc/medicine/19033/PIL/GARDASIL/

   In the meantime, the guidance in the updated HPV chapter of the Green Book and in this letter should be followed. The Green Book states:

Recommendations on immunisation procedures are based on currently available evidence and experience of best practice. In some circumstances, this advice may differ from that in vaccine manufacturers' Summaries of Product Characteristics (SPCs). When this occurs, the recommendations in this book (which are based on current expert advice received from the Joint Committee on Vaccination and Immunisation (JCVI)) should be followed.

See attached link to the Green Book chapter:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147915/Green-Book-Chapter-4.pdf

In the meantime, the guidance in the updated HPV chapter of the Green Book and in this letter should be followed.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317821/Green_Book_Chapter_18a.pdf

Additional information:

9. A revised information leaflet is being developed to reflect the changes which can be used as part of the consent process. An updated Q&A for health professionals to reflect the programme changes will be available shortly on the PHA website.

Conclusion

10. The HPV vaccination programme has been very successful in Northern Ireland and I would therefore urge all HSC Trusts and GPs to maintain this success in order to ensure girls are given the best protection against cervical cancer.

Yours sincerely

Dr Michael McBride	**Mrs Charlotte McArdle**	**Dr Mark Timoney**
Chief Medical Officer	**Chief Nursing Officer**	**Chief Pharmaceutical Officer**

This letter is available on the DHSSPS website at
www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications.htm

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Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, Health & Social Care Board
Director of Social Care and Children, HSCB
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