

# National Immunisation Advisory Committee

MEETING DETAILS	
Date (Venue)	25.09.2023 (Online via MS Teams)

ITEM	SUMMARY
<b>Introductions</b>	<ul style="list-style-type: none"> <li>• Apologies</li> <li>• Welcome to Dr Sarah Geoghegan, new NIAC Clinical Lead. Dr Bridget Freyne also welcomed as new committee member.</li> <li>• Dr Bryony Treston thanked for her work to date as interim clinical lead and will continue in her role as Technical Researcher.</li> <li>• Thank you to Dr Ciara Keane for her service with NIAC.</li> </ul>
<b>Statement of Interests</b>	No conflict of interest declared.
<b>RSV</b>	<p>An evidence synthesis of safety and clinical efficacy of RSV immunisation in infants and older adults was presented to the Committee.</p> <p>Epidemiology update</p> <ul style="list-style-type: none"> <li>• Overall circulation in recent weeks remains lower than the equivalent time periods in 2021 and 2022.</li> <li>• Some RSV deaths last season in the elderly. RSV mortality surveillance is being established.</li> <li>• International recommendations were reviewed. France, UK, USA, Spain have recommended the introduction of nirsevimab for infants for the 2023/24 season. RSV vaccination has been recommended in several countries for older adults.</li> <li>• While there has been notable increased awareness of RSV in older adults in recent years, incidence in older adults is likely under reported as RSV is still not routinely screened for in older adults in many healthcare settings.</li> </ul> <p><b>Infants</b></p> <ul style="list-style-type: none"> <li>• Consensus from committee that the infant cohort would benefit from a universal approach to passive infant immunisation. Both maternal vaccination and monoclonal</li> </ul>

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	<p>antibody products have acceptable safety and efficacy profiles. Nirsevimab should replace palivizumab for high-risk infants once available.</p> <ul style="list-style-type: none"> <li>• Certain complexities around the infant cohort need to be taken into consideration. Further recommendations, HTA and research in terms of logistics, ethics and cost-effectiveness should be undertaken taking secondary economic and social impacts into consideration.</li> <li>• It is not known how many infants and children receive palivizumab in Ireland each year.</li> <li>• Currently palivizumab is not procured through the NIO and they do not have experience with monoclonal antibody. There would have to be a discussion with the DoH to establish how this might best be achieved. This would require an additional procurement and administrative process. The logistics for this would also need to be considered.</li> <li>• It was noted that it would be a complex process to implement RSV vaccination in pregnant women and that there would still be a need for monoclonal antibody for very preterm babies</li> <li>• International data from this season may be helpful for programmatic considerations should nirsevimab be approved for introduction for the 2024/25 season.</li> </ul> <p><b>Older adults</b></p> <ul style="list-style-type: none"> <li>• Consensus in support of RSV vaccination of older adults (<math>\geq 65</math> years) with RSVPreF3 (GSK) or RSV preF (Pfizer).</li> <li>• Vaccine administration should take place prior to the anticipated start of the RSV season and should prioritise those of more advanced age and co-morbidities in the event of supply issues.</li> </ul> <p>It is unlikely that both programmes would be implemented at the same time. Two HTAs would likely be required prior to implementation.</p>
<b>Herpes Zoster</b>	<p>A presentation on herpes zoster (HZ) vaccine was shared with the Committee. Members of the SpR evidence review group were thanked for their work with an Umbrella Review.</p> <ul style="list-style-type: none"> <li>• Shingrix is licensed for the prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older and adults 18 years of age or older at increased risk of HZ.</li> <li>• Shingrix is a recombinant, attenuated vaccine which NIAC currently recommends in 'at risk' patients (immunocompromised, malignancy, SOT, HSCT, etc.,).</li> <li>• In Ireland, there were 48 deaths from HZ between 2007-2020, most in those aged <math>&gt;85</math> years (HPSC).</li> </ul>

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	<ul style="list-style-type: none"> <li>• Shingrix is generally well tolerated with good safety and efficacy data. Zostavax (live-attenuated) is less efficacious and will go out of production at the end of this year.</li> <li>• Vaccination with Shingrix has resulted in a significant reduction in HZ incidence in vaccine targeted groups internationally.</li> <li>• Immunity data for Shingrix in the immunocompetent is only available for ten years post vaccination, therefore the duration of protection beyond this time is unclear.</li> </ul> <p><b>Immunocompetent</b></p> <ul style="list-style-type: none"> <li>• Existing NIAC guidelines recommend HZ vaccination can be considered in adults <math>\geq 50</math> years (privately funded).</li> <li>• Committee welcomed the idea of a nationally funded program for older adults' and high risk groups.</li> <li>• Morbidity and mortality from HZV generally begin to occur at age 50, though hospitalizations increase significantly from age 65 years.</li> <li>• Vaccination at age 65 years would likely reduce most associated hospitalization and mortality and would coincide with age which pneumococcal vaccine is given.</li> <li>• Vaccination at age 50 years would avert the majority of cases and associated morbidity, though may necessitate a booster dose at a later date.</li> <li>• The cost of the vaccine may be a barrier to introduction to the programme and equity of access is an important consideration.</li> </ul> <p><b>Immunocompromised</b></p> <ul style="list-style-type: none"> <li>• Data on duration of protection from Shingrix currently limited to two years.</li> <li>• Discussion about age cut off for immunocompromised patients. Further evidence required to enable full consideration.</li> <li>• The Committee highlighted the importance of a detailed list of clearly defined conditions within the immunocompromised group.</li> </ul> <p>The secretariat will revert with supplementary evidence in respect of age considerations, and immunocompromised individuals to support a further discussion of potential recommendations in this area.</p>
<b>SARS-CoV-2 (COVID-19)</b>	<p>Epidemiology update</p> <ul style="list-style-type: none"> <li>• Overall COVID-19 activity has declined since the peak of summer wave. SARS-CoV-2 positivity has been decreasing in recent weeks. No increase in wastewater viral loads.</li> <li>• The BA.2.86 variant of less concern at present, no cases detected to date in Ireland. Not enough data available on BA.2.86 to indicate impact on clinical severity, transmissibility and growth rates.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Reduction in number of hospitalised cases in recent weeks.</li> <li>• Hospital and residential institution outbreaks decreasing, but a slight increase in nursing home outbreaks.</li> <li>• XBB variants dominating worldwide since February 2023.</li> </ul>
<b>Epidemiology updates</b>	<ul style="list-style-type: none"> <li>• Influenza and RSV: Activity is lower than that of 2021 and 2022 to date.</li> <li>• Mpox: Five cases in the last three weeks. Approximately 28,000 cases in Europe overall to date.</li> <li>• Hepatitis A: Thirty-five cases to date this year, trending lower than the previous two years.</li> <li>• Meningococcal disease: Thirty-two cases of IMD and two deaths this year to date (15sgB, 1sgW and 8 sgY).</li> <li>• Of eight cases in 2023 aged under nine years (one case &lt; two months of age, two cases aged 2 months and one case aged 6 months).</li> </ul>
<b>Chapter Updates</b>	<ul style="list-style-type: none"> <li>• Updates were reviewed by the Committee, no objections voiced.</li> </ul>
<b>Vaccine injury redress scheme</b>	Committee was informed by DOH that there was a consensus amongst stakeholders that a vaccine injury redress scheme should be established. Work is ongoing in the DOH on this.