MINISTRY OF HEALTH
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27 July 2009

To: Medical Officers of Health

From: Greg Simmons, Chief Advisor Population Health

Subject: Active and Passive Prophylaxis For Contacts of Measles

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Summary
This update is to advise that measles activity is continuing and that we are advising changes to the dosages of Human Normal Immunoglobulin (HNIG).

- Confirmed measles cases continue to occur
- Administering MMR should be considered from 6 months onwards (or earlier on a case-by-case basis) among susceptible contacts
- Changes to the dosages of NHIG are recommended for Immunocompetent infants under 12 months and pregnant women
- Intravenous Immunoglobulin (IVIG) Intragam®P can be considered for immune suppressed and deficient measles contacts or in those where large doses are required.

Measles Activity
The measles outbreak is continuing, with 106 notified cases for the year to 23 July. 59 (30 confirmed) of these cases are in Canterbury but other regions reporting confirmed cases from 1 June to 23 July 2009 include: Auckland (1) and Waikato (1).

MMR Post-exposure Vaccination
For infants and other healthy individuals where post-exposure vaccination is indicated MMR can be given within 72 hours of last exposure. Administering MMR should be considered from 6 months onwards among susceptible contacts. MMR can be considered on a case-by-case basis for those under 6 months of age, particularly if the child's mother has vaccine-induced immunity.

Human Normal Immunoglobulin prophylaxis for contacts
In susceptible pregnant contacts and others where indicated (vide infra) HNIG is given to attenuate disease and can be considered up to 6 days from last exposure. IG should be given to the following contacts of measles cases as soon as possible after exposure:

- Immunocompromised or immunodeficient children
- Pregnant women
- Immunocompetent children under 15 months beyond 72 hours from exposure
- People outside the 72 hour window for MMR who have not had a history of measles infection or vaccination

We have been informed by the New Zealand Blood Service that the level of measles-specific antibody in NHIG is lower than recommended measles specific antibody is between 14-16 IU/ml. This is significantly lower than the minimum potency of 50 IU/ml identified in the British Pharmacopoeia. The current MedSafe-approved datasheet for NHIG indicates a dose of 0.2mL/kg for measles post exposure prophylaxis. This is likely to be amended following further testing of the level of measles-specific antibody in NHIG.

The new recommended doses of NHIG are:
a) Immunocompetent infants (under 12 months) should receive 0.6mL/kg with a maximum volume of 5mL
b) Pregnant women, immunocompetent adults and immune compromised or deficient children with should receive 0.6mL/kg with a maximum dose of 15mL (recommended in three 5 mL injections).

Prophylaxis with Intravenous Immunoglobulin
IVIG (Intragam®P) can be considered for immune suppressed and deficient measles contacts (who may for example have a central venous catheter) or in those where large doses are required.

The recommended dose of intravenous immunoglobulin is 0.15g/Kg.

See the revised guidance from the Health Protection Agency for further information:
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1238565307587

If there are further queries can be directed to the New Zealand Blood Service medical team via the district health board blood bank.