Neonatal BCG immunization

Sirs,

Eastham and Wyllie in their study of neonatal BCG immunization within an acute Trust highlight a number of important problems concerning selective BCG programmes. The authors identify a number of modifications to their programme in the light of their findings to improve efficiency and effectiveness. We are concerned that there is little reference made to the roles of the Child Health Department or to the Consultant in Communicable Disease Control, who has overall responsibility for the local prevention and control of tuberculosis. Previous studies have found that improved coverage of neonatal BCG vaccination and adequate monitoring can be achieved using the Child Health Department and Maternity Computer systems in combination. It is our experience that such a combination, supported by the local Public Health Department, is vital to overcome the shortcomings of both systems.

Furthermore, the authors fail to adequately emphasize the difficulties in accurately identifying infants from ethnic groups who are considered at high risk for tuberculosis, especially those from mixed race families. These difficulties have been highlighted in previous audits of selective neonatal BCG programmes. There is no assessment within the study of the accuracy of the system described in identifying this ‘at risk’ group. Many infants born to one or both parents from high-prevalence ethnic groups are likely to have been missed by such a system and it is likely that actual vaccine coverage of this ‘at risk’ group may be considerably lower than the figure quoted in the study.

There is also no attempt by the researchers to explore the possible reasons accounting for the failure to attend of those who had been referred. Further research on this group, which accounted for just under a quarter of all those referred, may help identify important ways in which the programme could be improved.

Finally, Eastham and Wyllie note that information about immunization should be provided for parents during the antenatal period. Although we endorse the provision of information in any immunization programme, with respect to the selective BCG programme in neonates we believe this tactic could significantly improve coverage. The important of empowering parents through the provision of information and advice, using appropriate language and presentational formats, is becoming increasingly acknowledged and should be fully supported.

References

Yours faithfully,
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Reply

Sirs,

We read with interest the letter from Drs Duffell and Sarangi. They raise concern about lack of reference to the roles of the Child Health Department or the Consultant in Communicable Disease Control. The Neonatal Department works closely alongside that of Child Health, and the departments hold joint monthly audit meetings. As explained in ‘Implementation of Change’, the audit was widely disseminated. Further, the process development working party included the Consultants in Communicable Diseases, Community Physician with special interest in immunization, Consultant Chest Physician, maternity and paediatric nursing managers, TB Liaison Sister and representatives from two Community Midwifery teams. We therefore felt we implemented the kind of multi-disciplinary approach required.

Second, we agree with Duffell and Sarangi regarding possible difficulties in accurately identifying infants from high-risk ethnic groups. Fortunately, South Tees Acute Hospital Trust maternal information system documents both maternal and paternal ethnic group individually for each child. A child was deemed to be at risk if either or both parents were from high-risk ethnic groups. We acknowledge the limitations of the booking questionnaire regarding family history of TB, which has been modified during the development and review process. However, this would tend to overestimate the numbers at risk as it did not specifically ask about history of TB in close living relatives.

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