

## Letters to the Editor

Adrian K Thomas, FRANZCOG, FRCOG

Chairman, Rubella Committee, Deafness Foundation (Victoria)

**To the Editor:** The recent report by Hanna et al<sup>1</sup> of the importation of measles highlights the problem of common infectious diseases being inadvertently introduced into this country. Smallpox vaccination used to be a condition of entry into Australia. Since its abolition we have become somewhat complacent about the possibility of (relatively common) infectious diseases being imported into this country and have overlooked the fact that many migrants who come here have different 'immunity profiles' from the local population. This appears to be the case for measles and is certainly the case for rubella.

Of patients attending the Mercy Hospital for Women in Melbourne, 20 per cent of Chinese and 10 per cent of other Asian women had no detectable immunity to rubella, compared with 3 per cent of native born Australians.<sup>2</sup>

For a number of years the Deafness Foundation (Victoria) has been concerned about the level of susceptibility to rubella of migrant groups, especially those from Asia. Because these communities are often close-knit it is conceivable that a situation similar to that with measles described by Hanna et al could occur with rubella. Major consequences could occur if a pregnant woman were infected in this way because rubella can be subclinical, the infection may go undetected and spread rapidly.

The Deafness Foundation (Victoria) has been urging the Commonwealth Departments of Immigration and Multi-cultural Affairs, and Health and Aged Care to address this problem more aggressively; this both publicly<sup>3</sup> and in private presentations of its data to them. While there has been some response, it believes more could be done and it would almost certainly have to be done within Australia where the organisational structures are probably more established. In its experience the migrant population is willing to accept vaccination once its benefits are explained and compulsory vaccination is not necessary.

The Foundation endorses wholeheartedly the recent initiative of the Federal Minister for Health and Aged Care in introducing a 'catch up' programme for measles vaccination for young adults<sup>4</sup> – a policy it has been advocating for some time. The MMR vaccine will also address the problem of rubella susceptibility in adolescent males (who could act as a reservoir for an epidemic). As welcome as it is, however, is still does not specifically target those from overseas and the potential for epidemics will continue until immunity levels in this population group are brought much closer to that of the local population.

1. Hanna J, Richards A, Young D, Hills S, Humphreys J. Measles in health care facilities: some salutary lessons. *Commun Dis Intell* 2000;24:211-212.

2. Francis B, Thomas AK, McCarty C. Impact of rubella immunisation on the serological status of women of child-bearing age. A public health perspective. National Public Health Association Conference. September 2000.
3. Thomas AK. Immunisation – lifting our game. *Med J Aust* 1998;168:199.
4. Campbell M. Editorial. Young adult measles vaccination. *Commun Dis Intell* 2000;24:241.

### Guidelines for the control of measles outbreaks in Australia

Christine Selvey

Head Immunisation, Centre for Disease Control, Territory Health Services, Casuarina, NT 0810

**To the Editor:** The recently released national technical report, *Guidelines for the control of measles outbreaks in Australia*,<sup>1</sup> contains a definition of a susceptible person that is inconsistent.<sup>2</sup> This definition then guides all further recommendations in the document. According to the definition, all infants under 6 months of age are considered to have acceptable presumptive evidence of immunity to measles, unless the infected contact is the infant's mother. In an outbreak, babies under 6 months of age are not offered immunoglobulin or vaccination or excluded from childcare. But, if the mother was born after 1970, and does not have either documented evidence of having had two doses of a measles-containing vaccine or documented evidence of immunity or documented evidence of laboratory confirmation of measles, then she is considered to be susceptible. In an outbreak she will be offered vaccination if within 3 days of exposure, or immunoglobulin if 3 to 7 days within exposure and excluded from work until vaccinated.

So, if during an outbreak, a 28-year-old mother, without evidence of measles vaccination, measles immunity or measles infection, and her 4-month-old child are exposed to measles, the guidelines say that the mother is susceptible and requires protection, but the infant is not susceptible due to maternal antibodies! I would find this quite difficult to explain to the mother.

Perhaps the definition of an infant with acceptable presumptive evidence of immunity to measles should be something along the lines of: *Infants under 6 months of age whose mothers were considered to have acceptable presumptive evidence of immunity (born before 1970 or having had two doses of a measles-containing vaccine, laboratory evidence of infection or documented immunity) at the time of the pregnancy.* (The mother may have been vaccinated after delivery.)

1. Measles Elimination Advisory Committee. Guidelines for the control of measles outbreaks in Australia. *Commun Dis Intell* Technical Report Series No.5. July 2000
2. Ibid. p10.