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Vaccination Information for the 2006-2007 Influenza Season in Kentucky

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The annual supply of influenza (flu) vaccine and the timing of its distribution cannot be guaranteed in any year. Flu vaccine distribution delays or vaccine shortages remain possible in part because of the inherent critical time constraints in manufacturing the vaccine, due to the annual updating of flu vaccine strains. As of August 2006, flu vaccine manufacturers were projecting that approximately 100 million doses of flu vaccine would be available in the United States for the 2006-2007 influenza season, an amount that is approximately 16% more doses than were available for the 2005-2006 season. To ensure optimal use of available doses of flu vaccine, the Kentucky Department for Public Health is issuing the following recommendations (Table 1), in accordance with the Advisory Committee on Immunization Practices (ACIP) Recommendations for the Prevention and Control of Influenza.

Table 1. Kentucky Department for Public Health Vaccination Recommendations for 2006-2007 Influenza Season

	If the supply of inactivated flu vaccine is adequate	If a reduced or delayed supply of inactivated vaccine occurs
Vaccination Before October	• All patients - both high risk and healthy - with the exception of long term care facility residents due to more rapidly declining antibody levels after vaccination	• Persons at increased risk for serious complications and their household contacts[1] • Children aged 6 months -<9 years who have not been previously vaccinated
Vaccination in October and November	• All patients - both high risk and healthy • Long term care facility residents	• Persons aged ≥50 years • Persons aged <50 years at increased risk for influenza related complications[2] • Household contacts of persons at high risk[1] • Health-care workers • Vaccinations for healthy persons who wish to decrease their risk for influenza virus infection should not begin until November[3]
Vaccination in December and Later	• All patients - both high risk and healthy	• All patients - both high risk and healthy

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[1]including out-of home caregivers and household contacts of children aged 0-59 months
[2]including children aged 6-59 months
[3] if such persons request vaccination in October, vaccination should not be deferred, unless vaccine supplies dictate other wise

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Persons and institutions planning substantial organized vaccination campaigns (e.g., health departments, private physicians, occupational health clinics, and community vaccinators) should consider scheduling these events after mid-October because the availability of vaccine in any location cannot be ensured consistently in early fall. Scheduling campaigns after mid-October will minimize the need for cancellations because vaccine is unavailable. These vaccination clinics should be scheduled through November, with attention to settings that serve children aged 6-59 months, pregnant women, other persons aged <50 years at increased risk for influenza-related complications, persons aged ≥50 years, healthcare workers, household contacts, and out-of-home caregivers of persons at high risk (including children aged 0-59 months). Planners are encouraged to schedule at least one vaccination clinic in December.

During a vaccine shortage or delay, substantial proportions of inactivated influenza vaccine doses may not be released until November and December or later. Beginning in November, vaccination campaigns can be broadened to include healthy persons wishing to reduce their risk for influenza virus infection. ACIP recommends organizers schedule these vaccination clinics throughout November and December. When the vaccine is significantly delayed, agencies should consider offering vaccination clinics into January as long as vaccine supplies are available.

Campaigns using live attenuated influenza vaccine (LAIV), i.e., FluMist, are optimally conducted in October and November, but can also extend into January. Because LAIV is approved for use in healthy persons aged 5-49 years and is expected to be in adequate supply, no recommendations exist for limiting the timing and prioritization of administering LAIV. Administration of LAIV is encouraged as soon as it is available and throughout the season.

The CDC and the Immunization Program of the Kentucky Department for Public Health will assess the vaccine supply on a continuing basis throughout the manufacturing period and will inform both providers and the general public if a substantial delay or an inadequate supply occurs.

Colorectal Cancer Testing Can Save Your Life - Screen for Life

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Colorectal cancer is the third most common cancer in adults and the second leading cause of cancer related deaths in the U.S. According to the Centers for Disease Control and Prevention (CDC), if everyone age 50 and older had regular screening, at least one-third of colorectal cancer deaths could be avoided. Kentuckians have fewer regular screenings for colorectal cancer than people nationwide. The Healthy Kentuckians Mid-Decade Review shows that the percentage of Kentuckians age 50 or older who have ever had colonoscopies has increased to 47.2% from 34% in 1997, which exceeds the 2010 target. However, the percentage of those having the Fecal Occult Blood Test (FOBT) in the last one to two years had actually decreased from 26% in 1997 to 24%, despite a baseline target of 35% for 2010. Of all groups in the U.S. and Kentucky, African Americans have the highest incidence and mortality rate for colorectal cancer.

There are few symptoms early in the process of colorectal cancer, making early detection the key to success. Screenings should be started at age 50 for both men and women and earlier if there is a personal or family history of colorectal cancer. Screening for colorectal cancer is just as life-saving as screening for breast and cervical cancer and should be done as part of a routine physical. Colorectal cancer can usually be prevented by removing polyps before cancer develops. Colon cancer takes 5-15 years to develop from colon polyps.

While there are few early symptoms, some risk factors for developing colorectal cancer include:

- inflammatory bowel disease
- a personal or family history of colorectal cancer or colorectal polyps
- other lifestyle factors that may include:
  - excessive alcohol consumption
  - tobacco use
  - a diet low in fruit, vegetable and fiber

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- obesity and lack of regular physical activity

American Cancer Society (ACS) guidelines for screening and surveillance for the early detection of adenomatous polyps and colorectal cancer were updated in 2001 and recommendations for stool blood testing were modified in 2003 by adding fecal immunochemical tests if available. There are a number of options for colorectal screening based on individual risk, personal preference and access. For average risk individuals the following are recommendations for screening:

- FOBT (fecal occult blood test) - an annual test that examines stool samples for blood. These kits are obtained from the physician or health provider. This test is recommended yearly. Many physicians take the opportunity to perform FOBT with stool acquired during a Digital Rectal Exam (DRE). Clinicians should emphasize annual FOBT testing for patients who choose only to be screened for colorectal cancer with stool blood tests. Even when an FOBT is done properly, there is a low sensitivity for detecting the possibility of an advanced neoplasm. One negative FOBT in the physician's office may also give a false sense of reassurance and is discouraged as a standard of care. For accurate screening, three separate stool samples should be analyzed.
- The fecal immunochemical test (FIT) is more specific that the FOBT and is available in limited areas although expense is a factor. This test could be substituted yearly for the FOBT.
- Sigmoidoscopy - a visual exam using a lighted scope to detect problems in the rectum and lower portion of the colon where approximately 60% of cancer is found. Recommended every five years beginning at age 50 for those who are low to average risk.
- Colonoscopy - a visual exam using a longer lighted scope to view the rectum and the entire colon. Recommended every 10 years beginning at age 50.
- Double-contrast barium enema test – an x-ray of the colon and rectum. Recommended every 5 years and may be done along with a sigmoidoscopy.
- Other tests currently are being evaluated in certain research settings and are also available to a limited degree to the public. These include stool DNA testing and computerized tomography exams of the colon, also referred to as virtual colonoscopy. While not recommended at this time, the ACS is carefully monitoring research on these tests. Additional data collected during the National Health Interview Survey (NHIS) also indicated that as many as one third of adults who reported a positive FOBT also reported that they received no follow-up. These findings indicate the need for a highly focused educational campaign to help clinicians understand that FOBT testing should follow manufacturer's instructions, and that positive tests should be followed up with a colonoscopy according to the ACS. An excellent self-study multimedia CME/ CEU is available on Colorectal Cancer Prevention and Early Detection at the ACS Web site (www.cancer.org).

Medicare and Medicaid have implemented coverage for colorectal cancer screening including coverage for colonoscopy. Most insurance covers testing, although co-pays and deductibles vary according to plan and pocket expenses may reach $500-1000. Persons with limited insurance coverage or self-pay are less likely to follow through with recommended screening and colonoscopy. Most studies show that a lack of access to early detection tests and preventive methods such as colonoscopy with polyp removal increases the risk for late-stage cancer. Since 1999, the CDC and the Centers for Medicare & Medicaid Services (CMS) have created and implemented *Screen for Life: A National Colorectal Cancer Action Campaign*, a multimedia effort promoting colorectal cancer screening.

The Kentucky Department for Public Health (DPH) works with the Kentucky Cancer Consortium to make a difference in the lives of Kentuckians through a collaborative effort of many partners. In 2006, mini-grants were given to several health departments in order to provide education and increased screening for colorectal cancer.

For more information regarding colorectal cancer screening, contact the DPH Chronic Disease Prevention and Control Branch at (502) 564-7996.

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September is 5-A-Day Month!

Elizabeth Fiehler, MS, RD, LD, Nutrition Consultant, Nutrition Services Branch

September is observed as 5-A-Day Month. The goal is to increase the number of fruit and vegetable servings Americans eat to five a day, in addition to incorporating this into a long-term lifestyle change in order to improve one's overall health and decrease the risk of illness.

The Centers for Disease Control and Prevention (CDC) found in 2002 that only 20.2% of Kentuckians eat five or more fruits and vegetables per day. By making changes to add additional fruits and vegetables to the daily diet, residents of Kentucky can improve their health and also improve the health of loved ones by setting a healthy example.

The consumption of fruits and vegetables has numerous benefits. Some of these benefits include reducing a person's risk for disease such as cancer, cardiovascular disease, stroke, hypertension, birth defects, and diabetes to name a few. The addition of fruits and vegetables to the daily diet may also assist in losing weight or maintain a healthy weight and help to improve the health of employees, leading to fewer sick days and increased productivity.

Eat a variety of colorful fruits and vegetables — green, yellow/orange, red, blue/purple, and white — for better health. For more information on 5-A-Day or to learn more about the health benefits of colorful fruits and vegetables, visit www.5ADay.com or contact Elizabeth Fiehler, Department for Public Health Nutrition Services Branch, at (502) 564-3827, Ext. 3589.