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# CDC Telebriefing Transcript

## ACIP Smallpox Vaccine Meeting Briefing

October 17, 2002

CDC MODERATOR: Thank you, John.

This is Von Roebuck in CDC's Office of Communications. Welcome everybody, and thank you for your patience. I wanted to make sure everybody could get on-line.

This is a media briefing for the Advisory Committee on Immunization Practices. With me today are Dr. John Modlin, and Modlin is spelled M, as in Michael, O-D, as in David, L-I-N, as in Nick. He is the chair of the Advisory Committee on Immunization Practices.

Also with me is Dr. Walt Orenstein, O-R-E-N, as in Nick, S, as in Sam, T, as in Tom, E-I-N, as in Nick. He is the director of CDC's National Immunization Program.

We're going to open today with a brief statement by Dr. Modlin, and following the statement, we will take questions and answers.

Dr. Modlin?

DR. MODLIN: Thank you, Von.

I have a prepared statement here, which I will release. As part of its regularly scheduled October meeting, the Advisory Committee on Immunization Practices, the ACIP, addressed a number of issues related to smallpox vaccination in the past two days.

As many of you know, in June 2001, the ACIP made recommendations for the use of smallpox vaccine to protect persons who work with orthopox viruses to prepare for a possible bioterrorism attack and to respond to an attack involving smallpox.

Earlier this year, in June 2002, the ACIP issued draft supplemental recommendations for smallpox vaccine. A major element of our June 2002 statement was the recommendation of state and local health officials designate people who would respond to, and care for, a suspected or confirmed case of smallpox. Specifically, the ACIP recommended voluntary vaccination of people serving on what subsequently has been designated, one, Smallpox Public Health Response Teams and, two, Smallpox Health

Care Teams.

Last month, the CDC asked the ACIP for additional guidance regarding smallpox vaccination. There were eight issues that CDC asked the ACIP and another Advisory Committee, the Hospital Infection Control Practices and Advisory Committee or HICPAC to address. For the past month, the working group, with members from both the ACIP and HICPAC, has been working on these eight issues.

The first issue involves better defining the types of health care workers that should be included on the Smallpox Health Care Response Team. The other issues included:

One, how should the smallpox vaccination site be cared for;

Two, should health care workers who are vaccinated made to be placed on administrative leave as a result of smallpox vaccination;

Three, what type of screening should be done before someone receives a smallpox vaccination, specifically what is recommended with respect to screening for pregnancy, HIV infection, and atopic dermatitis, all of which are contraindications for smallpox vaccination;

Four, is it okay for people to receive other vaccines, such as influenza vaccine at or near the same time as they receive smallpox vaccination; and,

Five, should people who are doing smallpox vaccinations be vaccinated themselves before they administer a smallpox vaccination?

Before I briefly summarize the ACIP's recommendations in each of these areas, I want to make a few points regarding the process.

First, the ACIP's recommendations request considerable consultation with the Hospital Infection Control Practices Advisory Committee, HICPAC, and DHHS's National Vaccine Advisory Committee or NVAC.

The Health Care Infection Control Practices Advisory Committee provides advice and guidance to the CDC and DHHS regarding the prevention and control of health care-associated sections in hospitals, long-term health care facilities and home health agencies.

The ACIP recommendations are being forwarded to HICPAC, where there was even consideration of their meeting next week. This meeting will be held in Atlanta on October 22nd and 23rd. In coming weeks, the joint ACIP-HICPAC recommendations will be forwarded to CDC and DHHS for their review and consideration.

I will now briefly summarize what the ACIP is recommending regarding the eight smallpox vaccine issues that they've been asked to address.

First, with respect to Smallpox Health Care Response Team, the ACIP is recommending that these teams include people with a range of skills and expertise, with particular emphasis on emergency room physicians and

nurses, intensive care unit staff, infectious disease specialists, medical personnel with smallpox experience and other medical specialties, including dermatologists, pediatricians, ophthalmologists, pathologists and surgeons.

In addition, we recommend the Smallpox Health Care Teams include radiology technicians, respiratory therapists and proactive security and housekeeping personnel.

The ACIP recommends that hospitals establish at least two Smallpox Health Care Teams to ensure adequate care. This is particularly true for acute-care hospitals that have airborne infection isolation rooms. We may need to revisit that last sentence.

With respect to care of smallpox vaccination sites, the ACIP recommends that health care workers involved in direct patient care should keep their vaccination sites covered with gauze or similar absorbent material in order to absorb exudates that would develop.

We recommend that health care workers keep the vaccination site covered, not during direct patient care, until the scab separates. The reason that we make this recommendation is that vaccinia, which is a live virus mutant smallpox vaccine, can be transmitted by direct person-to-person contact, and steps should be taken to reduce this likelihood.

With respect to administrative leave for vaccinated health care workers, the ACIP does not believe that health care workers need to be placed on leave because they receive smallpox vaccination. Administrative leave is not required [inaudible] for newly vaccinated health care workers unless they are physically unable to work due to systemic signs and symptoms of illness or, if they do not adhere to the recommended infection control precautions.

It is also important to note that the very close contact required for transmission of vaccinia to household contacts is unlikely to occur in the health care setting, and I think that's an important point to underscore.

With respect to screening for eczema or atopic dermatitis, the ACIP is recommending that anyone with these and other skin conditions not receive smallpox vaccine. Further, we also recommend not giving the vaccine to anyone who has a family or household member with these conditions.

With respect to pregnancy, smallpox vaccine should not be administered in a pre-event setting to pregnant women or to women who are trying to become pregnant. Before vaccination, women of child-bearing age should be asked if they are pregnant or intend to become pregnant in the next four weeks. Women who respond positively should not be vaccinated. In addition, women who are vaccinated should be counseled not to become pregnant during the four weeks after vaccination. However, routine pregnancy testing of women of child-bearing age was not recommended.

With respect to screening for HIV infection, persons with HIV infection or AIDS are at increased risk of progressive vaccinia or vaccinia necrosum following smallpox vaccination. Therefore, smallpox vaccine should not be

administered to persons with HIV infection or AIDS. Before vaccination, potential vaccinees should be educated about the risks of severe complications from smallpox vaccine among persons with HIV infection or other immunosuppressive conditions. Persons who think they may have one of these conditions should not be vaccinated.

The ACIP does not recommend mandatory HIV testing prior to smallpox vaccination, but recommends that HIV testing should be readily available to all persons considering smallpox vaccination. HIV testing is recommended for persons who have any history of a risk factor for HIV infection and who are not sure of their HIV infection status.

Smallpox vaccine may be administered at the same time as any inactivated vaccine, including influenza vaccine. With the exception of varicella or chicken pox vaccine, smallpox vaccine may be administered simultaneously with other vaccines that contain live viruses.

In order to minimize the clinical impact of inadvertent inoculation, should it occur, the ACIP recommends that all persons who administer smallpox vaccine be vaccinated beforehand. Vaccination of this group will also contribute to preparedness for smallpox response. Should smallpox release occur, the development of a cadre of vaccinated, experienced vaccinators who could immediately be deployed for outbreak response.

That is a summary to ACIP's recommendations, and now Walt and I would be happy to address any questions that you may have.

CDC MODERATOR: Thank you, Dr. Modlin.

I must tell folks this is both an in-person as well as the folks that are here in person. I'd like to open up, though, to the folks in person. If you would identify yourself and what media you're from, both on the phone as well as in person. I'd appreciate it. So the floor is open here at the media briefing for anybody in person. Okay. We're thinking here. Let's take our first call on the phone then, please.

AT&T MODERATOR: And just a quick reminder for those on the phone, if you do have a question please press the one, and we have a question from Jim Lesher, National Public Radio. Please go ahead.

[No response.]

AT&T MODERATOR: We will move on to Emma Hitt [ph], Reuters Health. Please go ahead.

QUESTION: Yes. Hi. You mentioned that certain health care workers would be vaccinated and can you speak to the issue of the family members of those health care workers who've become vaccinated, and who they will have close contact with.

DR. ORENSTEIN: I think the, many of--the contraindications would include many of the same conditions. So, for example, if a health care worker has a child in the home with eczema, then that worker should not be vaccinated. If the worker has a household contact, someone with severe

immune suppressive illness, than that worker should not be vaccinated.

So that the same kinds of contraindications that are considered for people in vaccination would be applied also to household contacts, since, really, the vaccine virus, vaccinia, can be transmitted.

QUESTION: Thank you.

CDC MODERATOR: Thank you, Dr. Walt Orenstein. Can we have our next question from the phones, please.

AT&T MODERATOR: That's from Marin McKenna [ph] of Atlanta Journal. Please go ahead.

QUESTION: Hi. A question for either Dr. Modlin or Dr. Orenstein. Do you have any kind of a numerical estimate of how many Americans generally, and how many members of the class of health care workers that we're talking about might be likely to suffer from eczema or atopic dermatitis, and therefore might be subject to medical rollout?

DR. MODLIN: We've been relying on colleagues who are experts in dermatology, who represent the American Academy of Dermatology, to assist us in making these assessments.

It appears that the best numbers that we've been given, that perhaps as many as between 7 and 17 percent of all persons may either have atopic dermatitis or had a history of atopic dermatitis. To that extent it goes across all age groups. When we look at adults only, that number appears to be somewhat smaller and we are working with the assumption that somewhere between 2 percent and 5 percent of adults will give us the history that they either currently have problems with atopic dermatitis or have a history of that condition.

However, our precautions for administering smallpox vaccine actually extend to a large number of individuals with a skin condition, and they would include persons who have eczematous skin conditions, who do not know what the cause of their eczematous condition may be.

And they may include people who do not have the medical condition, atopic dermatitis, but may have something else that has been termed eczema, such as a chronic or recurrent dermatitis as a result of contact dermatitis. But they--for instance, some people have chronic contact dermatitis with [inaudible] nickel or from poison oak, or poison ivy.

Those persons we would not necessarily expect to be at risk from vaccination so long as they did not have active dermatitis at the time.

But, on the other hand, we recognize that many clinicians, particularly pediatric practitioners, do not readily make a distinction between the term eczema and between the term atopic dermatitis, and therefore in order to err on the side of being safe we are suggesting that persons who either have eczema, a diagnosis of eczema, or have it diagnosed as atopic dermatitis, not be immunized, again, unless they know the actual cause of their eczematous skin condition is not atopic dermatitis. I hope that's not

sufficiently confusing.

QUESTION: Can I ask a follow-up?

DR. ORENSTEIN: Can I add to that? I think the concern that we have is people who will develop what is called a generalized eczema vaccinatum, so even if they've got a past history of atopic dermatitis, and even if they have been mild in the past, the concern is that with vaccinia or smallpox vaccine, they can get total body involvement for large sections of their body.

That's a group we're most concerned about, that's the most severe consequence. For people who have other kinds of skin conditions, the concern is that that area of affected skin can get superinfected by sort of--if you scratch your vaccination site and then scratch your skin lesion.

And so that would focus only in the area of skin that's infected. So there's a big difference, which is why we try to differentiate a contact dermatitis like poison oak or poison ivy versus atopic dermatitis which can lead to much more severe illnesses.

QUESTION: Can I ask a follow-up?

CDC MODERATOR: Quickly, please.

QUESTION: Dr. Modlin, you said I think you're working on the assumption that 2 to 5 percent of adults will give you a history of problems of atopic dermatitis. That seems an awfully low percentage compared to the 20 percent rule out for skin conditions that Dr. Belshe [ph] had in St. Louis. Can you bring those two into concordance in some way?

DR. MODLIN: Certainly. Dr. Belshe of course is studying vaccine under experimental conditions, under what we call an investigation of a new drug, or IND study, so that they of course were taking every single precaution that they could to absolutely reduce the risk to individuals who are volunteering to participate in the research study. So that they're being extra super cautious.

And he found that, I believe he said somewhere between 10 and 20 percent may have some exclusion based on some kind of skin condition, and they interpreted chronic skin condition very, very broadly in that study.

The 2 to 5 percent is a number--it represents the number of adults that we believe truly do have the condition atopic dermatitis, either have the condition or have a history of having had that condition.

So this is to represent the group that we would consider truly to be at risk. We also recognize that there's going to be a larger number of people who either they themselves or even their physicians do not distinguish what they have from atopic dermatitis, who in reality probably have a very low risk from vaccination but who, because of the difficulty in readily distinguishing them from people who do have atopic dermatitis, the committee is suggesting that they not be vaccinated, again, unless they're certain that they know the difference. Does that help?

That number is likely to be larger and may approach the numbers that Dr. Belshe mentioned of 10 to 20 percent.

CDC MODERATOR: Thank you, Dr. Modlin. Thanks for your patience.

We have one question come down from the floor, please. Please identify yourself and the media.

QUESTION: Brian Bachtel [ph] with Infectious Disease News and infectious disease in children.

I have a two-part question really. The first part, as I understand, your contraindications go above and beyond [inaudible] so I was wondering if you had some kind of feel on the total percentage, the total number of the population that would be excluded or contraindicated against vaccination?

DR. MODLIN: Well, the numbers that we looked at, as you'll recall, that were the skin conditions that were overwhelmingly the largest number that we'd expect, and in fact the number of people that would fit the other category, the number of health care workers that might fit in the other categories that we would worry about are far, far smaller.

So I think in reality that number will be driven by, almost completely determined by the number of people that would have a chronic skin condition.

QUESTION: Do you have any idea what kind of--what contraindication [inaudible] 5 percent of people have, will do to the risk reduction or overall risk of adverse events from smallpox vaccination if mass vaccination [inaudible].

DR. MODLIN: I'm sorry. I don't quite follow you. We of course are not talking about mass vaccination right now. We're talking about a very restricted vaccination program.

QUESTION: Then let me limit the question.

The health care workers who will be vaccinated, pre-event, what will contraindicating do? How [inaudible] the presence or existence of adverse [inaudible] after vaccination?

DR. MODLIN: We would hope it would substantially reduce the risk. Again, we think that this is the group that is by far the highest risk, numerically, and if we are successful at preventing this group of individuals from being vaccinated, it should have a substantial effect.

It should reduce the number of adverse events, I would think by well over 50 percent, and probably quite a bit higher than that, if we successfully treat, defer from immunization--Walt [inaudible].

DR. ORENSTEIN: I think the Israelis estimated, in the past, that they could reduce by very rigorous screening, about a two-thirds reduction in the incidence of severe adverse events. But I'd like to emphasize there still will be severe adverse events.

There are events for which we have no risk factor, such as post-vaccinal encephalitis which could be extremely severe and that no screening system can perfectly eliminate of these severe adverse events.

DR. MODLIN: If I might add to that. Most of the cases of post-vaccinial encephalitis occurred in young children, and we're talking about this initial phase of vaccination, we're focusing on adult health care workers.

CDC MODERATOR: Thank you, Dr. Modlin.

We'll take our next call from the phones, please.

AT&T MODERATOR: Yes, a question from Maggie Fox, Reuters. Please go ahead.

QUESTION: Hi; thanks. That was my question, was in this population do you expect the numbers of severe adverse events to be reduced, because presumably these are mostly fairly young healthy adults?

DR. MODLIN: I think the numbers would be reduced if the screening recommendations are implemented well in all different sites where it may go on. How well that will go on is difficult to say, certainly. But I think it would have a marked decrease. I think we also need to realize that a number of the health care workers are older.

Now many of them may have had prior vaccination and that also may lead to a reduction in adverse events, although a substantial gap between when they were vaccinated, when they will be vaccinated this time, makes it difficult to know just how much of a reduction in the older health care workers we would get.

CDC MODERATOR: Thank you.

Go ahead.

QUESTION: Good afternoon. I was just hoping that either of you could maybe review for us, and I know that some of this is already out there, but I'd like to get it from the source, but if you could estimate, under the recommendations that you've approved in this two-day meeting here, roughly, how many health care workers might that apply to, about how many hospitals do you expect would it apply to?

And sort of second to that, can you describe for us any of the concerns that you've heard from the community of health care workers that you think are addressed by the changes that you've made to your June recommendation?

DR. MODLIN: John Modlin, and perhaps Walt may very well want to respond as well.

First of all, I'd like to point out that the objective of our recommendations is to assure that there are an adequate number of health care workers to provide care for the first wave of smallpox victims and that we are not focusing on a specific number, a target number of individuals to be

immunized, but rather the objective is to identify and to suggest that there be a sufficient number of health care workers in different categories that we've just talked about to provide care in many, if not most, of the acute-care hospitals in this country.

It turns out there, there are approximately 5,100 acute-care hospitals in the United States, and if--a big if--all of them were to take part in this program, we would estimate that there might be roughly, and I want to emphasize very roughly approximately 100 health care workers into those hospitals that might be needed to be vaccinated in order to meet that objective, and so if you do the math, that number comes up to about 500,000 health care workers.

However, we fully intend that there will be considerable differences between, and different needs, and different assessments of needs of numbers of health care workers from hospital to hospital and from location to location, and we intend that there be some flexibility. It may very well be that it's far better to leave the decision, in terms of the actual number of health care workers in any one hospital left up to not only the local public health authorities, but the people who are ultimately making the decisions in those hospitals themselves. They know their staff far better than we do.

Your second question was what do members of these affected professions think about this. At this particular meeting, we did not have specific feedback from representatives of these professions, although our work group that has been meeting prior to this meeting has had some feedback.

I think, if I could summarize it just very briefly, I would think that for the most part we have understood that people, organizations representing emergency room physicians, nursing staff and others have been very supportive of the process and have participated and, more or less, agree with what the ACIP's actions, in general, [inaudible], including the June meeting and the measures that we took today.

Walt, did you want to add?

DR. ORENSTEIN: I just want to emphasize, again, the goal is a cadre of people who could care for the first several patients in the first seven to ten days on a 24-hour basis. Hospitals have a lot of experience with figuring out what staff they need to care for patients who would be in isolation rooms with negative pressure, and so that's why we're a little uncomfortable with trying to name an actual number for you; that, in fact, the number will come from the hospitals if they decide what staff are needed to cover these patients.

What the ACIP did is give, in a sense, the kinds of staff that will be needed to care of several patients over that period, as we would vaccinate other staff as soon as a case hit the hospital, so that we would be able to have many more staff caring for patients as time went on.

CDC MODERATOR: Thank you, Dr. Orenstein.

Let's take our next question from the phones, please.

AT&T OPERATOR: That's from Richard Knox, NPR. Please go ahead.

QUESTION: All right. Thanks.

I gather that the committee is not addressing the question of the pacing of the vaccination of these health care workers; in other words, whether you're saying anything about doing a group and then surveilling those people to see what the experience is before doing another group.

DR. ORENSTEIN: I think the committee actually did talk about getting some experience and not necessarily doing, for example, all of the workers in a hospital on one day, but getting some experience with care, how the systems are working, how the adverse--the classification screening is working, to phase it in, as opposed to doing it all once, so that one could learn and adjust the system based on those early experiences.

DR. MODLIN: John Modlin. Let me just add another footnote that I think it was the sense of the committee that for most programs it would be wise to initially begin with older health care workers who have a history of having been immunized in the past, to further reduce the likelihood of adverse events, and therefore make it a little bit easier to do the administrative issues and procedures that Walt has just mentioned. That inevitably will take some time.

And it is important to develop sufficient experience with these things so that once you begin to immunize younger health care workers who, as primary vaccinees, we know will be at higher risk of having adverse complications, that there will be some experience before large numbers have been immunized.

Again, I'd like to emphasize all [inaudible] track the clear sense of the committee, and I'm certain that this will be reflected once we get around to preparing a formal statement, will be that programs should approach this in a rather deliberative way. I'm not necessarily terming it a "go slow" approach, but at least a careful approach so that there are opportunities to make adjustments as necessary.

CDC MODERATOR: Thank you, Dr. Modlin.

Let's take another question from the phones, please.

AT&T OPERATOR: And that's from Delphia Ricks, Newsday. Please go ahead.

QUESTION: Dr. Modlin, do we have any idea approximately how many health care workers there are in the country as a whole, the entire population? I'm just trying to get a sense of what percentage this rough estimate of 500,000 would be.

DR. MODLIN: It depends on how you identify and define a health care worker. It's my understanding that there are approximately 5 million health care workers who work in hospitals. There are approximately maybe slightly more than double that number when you include health care workers that maybe work in physicians' offices, when you include emergency medicine technicians who might not be included as hospital workers. We include dentists, allied health care workers, and I'm sure there are others. I think that big number may ultimately be as high as

somewhere between 10 and 12 million.

CDC MODERATOR: Thank you, Dr. Modlin.

Let's take another question from the phones, please.

AT&T OPERATOR: And that's from Scott Jenkins, FDC Reports. Please go ahead.

QUESTION: Thanks. My question was actually answered a few minutes ago, but I appreciate it.

CDC MODERATOR: Thank you, Scott. Let's take the next question from the phones, please.

AT&T OPERATOR: No further--oh, excuse me. We do have a question from the line of Gary Condin, Hartford Courant. Please go ahead.

QUESTION: Hi. I'm just wondering, from either of the doctors, what is the soonest this could begin nationwide?

DR. ORENSTEIN: I think what will happen is a process. There is a meeting next week with the Health Care Infection Control Practices Advisory Committee, and CDC will evaluate it, and that will be evaluated by departments. So I think it depends on what the decision is, which will be made at the White House, and then how soon they feel it needs to be done regarding the national security interests.

So I think we would work as quickly as we can, depending on what the decision is.

CDC MODERATOR: Thank you, Dr. Orenstein.

Are there more questions on the phone?

AT&T OPERATOR: Yes, we do have a question from the line of Julia Somerfield, MSNBC.com. Please go ahead.

QUESTION: Hello. I'm wondering if in the case of a smallpox attack, people with HIV or skin conditions would then be vaccinated.

DR. ORENSTEIN: For persons who are actually potential contact of smallpox cases, there really are no contraindications, since we're talking about a disease, ordinary smallpox have a morality rate of about 30 percent. So that for those kinds of people we would recommend vaccination if there contacts of somebody with smallpox.

CDC MODERATOR: Thank you, Dr. Orenstein.

Further questions on the phone lines?

AT&T OPERATOR: Yes, a question from the line of Tammy Smith, Richmond Times Dispatch. Please go ahead.

QUESTION: Hi. Thanks for taking my call.

I did not hear any mention of paramedics, emergency medical service records. I just had a question about them. Are they included in these recommendations?

DR. MODLIN: There certainly was a lot of discussion, both amongst members of the work group and amongst members of the committee yesterday whether or not to have emergency room technicians or, I'm sorry, emergency medical technicians should be included.

There are approximately 800,000 ENTs in the U.S. The feeling was that it was, number one, unlikely that risk for any one ENT technician to be exposed to smallpox is likely to be low, so that providing personal protection for them was not our first goal; and, secondly, that they may be somewhat less, slightly down the scale, somewhat less important on the hierarchy with respect to persons who we necessarily must immunize in order to adequately care for a hospitalized smallpox patient, and so that the ultimate decision, at least for this early go-around, is not to include emergency medicine technicians in these initial set of recommendations.

CDC MODERATOR: Thank you, Dr. Modlin.

Next question by phone?

AT&T OPERATOR: It's from John Lauerman [ph], Bloomberg News. Please go ahead.

QUESTION: Hi. Thanks for taking my question. I came in a little bit late, and I don't know if you talked about this before, but is there any evidence to suggest that covering the inoculation itself or that any particular type of dressing will prevent the transmission of vaccinia virus. And I apologize if this has already been discussed.

DR. ORENSTEIN: There are data that show that covering it with gauze and then at least a single layer of [inaudible], that you substantially reduce the likelihood of finding virus outside the dressing, and so that formed the basis of the ACIP's conclusion that workers could work, as long as they had these kinds of dressings in place.

DR. MODLIN: And, incidentally, let me just point out that in the statement that I read at the beginning, and I did want to come back to this, but the committee actually recommended in addition to being covered with gauze that at least a single layer of [CORRECTION: semi-permeable occlusive] dressing be used for health care workers, and that was not included in the original statement that I read.

CDC MODERATOR: That was Dr. John Modlin, and Dr. Walt Orenstein provided the first comment.

Do we have another question by phone?

AT&T OPERATOR: Yes, we do have a follow-up from Richard Knox, NPR.

QUESTION: I think you partially answered this, but just to be sure, decades ago, when vaccination of health care workers was routine, I gather that they did try to do it at times when people were going to be going off on holiday to try to minimize the risk, and so I wonder what the basis is for your feeling that that kind of thing isn't necessary this time around.

Is it the availability of semi-permeable dressings?

DR. MODLIN: No. This is John Modlin. That's not the reason.

The health care work place is very different today than it was 30 and 40 years ago, and we are faced with major shortages, particularly with nursing personnel, but with other allied health care personnel, that wind up being limiting factors in taking care of patients who are very sick.

And it was felt that, one, that trying to coordinate vaccinations for people who always have scheduled leave or scheduled vacations, probably administratively too complex to carry out and actually providing administrative leave because a person has been immunized might actually disrupt acute-patient care to a greater degree and put patients at greater risk than having them [inaudible] in their usual occupation with adequate coverage, and it's important to emphasize them paying close attention to universal precautions, which includes washing your hands regularly in carrying out their medical and nursing activities.

I'd like to also emphasize that the information, the best information we have, and that of course is from vaccination of health care workers in past decades, is that the risk of transmission of vaccinia virus, the smallpox vaccine virus, in the health care setting, in the hospital setting is extremely low. In fact, the numbers of cases that have been reported generally numbers a very small number.

So a far more greater concern or a somewhat greater concern would be risk of transmission not in the health care setting, but from a health care worker to someone who might be vulnerable in the household. That actually would be a greater concern.

CDC MODERATOR: Thank you, Dr. Modlin.

We'll take our final question from the phone, please.

AT&T OPERATOR: And that's from Leslie Wade, CNN. Please go ahead.

QUESTION: Yes, I wondered you, the ACIP recommended that this group of health care workers receive the vaccine first. Who would get it, which group after that? Is there another group or would it go straight to the general population? In other words, would we go to the first responders, then the general population?

DR. ORENSTEIN: I think what you're asking is what is going to be the policy decision, and that has not been made yet. There are all sorts of options that are being done, including a potential staged approach, and I think it will depend on what that policy is.

At the moment, the focus has been on those people who are at greatest risk for the spread of--for having smallpox spread to them should there be an attack, and that's the focus of the committee, and they need to deal with that particular group. And then depending on what the policy is, we will have to come back and review how best to implement whatever policy is recommended.

CDC MODERATOR: Thank you, Dr. Orenstein.

I'll take our final question in person, please.

QUESTION: Larry Altman [ph], New York Times.

What chance is there, if any, that there will be no vaccinations give to the health care workers, the 500,000 estimated? Is there any chance that none of them will get it?

DR. MODLIN: As I understand it, that is one of the options that is being discussed is no vaccination. This really depends on what the threat assessment is, and that is a decision that will be coming at the highest levels of the Executive Branch.

CDC MODERATOR: Thank you.

I will ask now for any final comments either from Dr. Modlin or Dr. Orenstein before we close the briefing?

DR. ORENSTEIN: None from me.

DR. MODLIN: None from me.

CDC MODERATOR: Thank you both. Again, Dr. John Modlin has been here, as well as Dr. Walter Orenstein.

I want to remind folks that the telebriefing transcript will go up on the Centers for Disease Control and Prevention's website later on this evening, so you certainly can see the information that was translated today.

Thanks again for your patience and listening. Take care.

[Whereupon, the telebriefing was concluded.]

Listen to the telebriefing



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