Hepatitis A Vaccine Information

Indications for use of vaccine

Hepatitis A vaccine is recommended for

- Travellers (who do not have natural immunity to hepatitis A) visiting areas of moderate or high hepatitis A endemicity, especially if sanitation and food hygiene are likely to be poor. Epidemiology
- Travellers with chronic liver disease. Although not at greater risk of hepatitis A infection, the disease can produce a much more serious illness in this group.
- Travellers whose sexual behaviour is likely to put them at an increased risk. A significant increase in hepatitis A has been noted in men who have sex with men.1,2
- Other specific indications for vaccination can be found in Immunisation Against Infectious Disease

Availability of vaccine

There are several vaccines licensed for use in the UK, all of which are inactivated.

Details of these and manufacturers can be found in the summary table below.

There are also combined hepatitis A and B, and hepatitis A and typhoid vaccines available.
## Vaccine schedules

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Manufacturer/distributor</th>
<th>Schedule</th>
<th>Length of Protection*</th>
<th>Age range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avaxim</td>
<td>Aventis Pasteur MSD</td>
<td>2 doses, given 6-12 months apart</td>
<td>10 years following booster*</td>
<td>Adults from 16 years</td>
</tr>
<tr>
<td>Epaxal</td>
<td>Swiss serum and Vaccine Institute</td>
<td>2 doses, given 6-12 months apart</td>
<td>20 years following booster*</td>
<td>Adults &amp; children from 2 years</td>
</tr>
<tr>
<td>Havrix Monodose</td>
<td>GlaxoSmithKline</td>
<td>2 doses, given 6-12 months apart</td>
<td>10 years following booster*</td>
<td>Adults from 16 years</td>
</tr>
<tr>
<td>Havrix Junior Monodose</td>
<td>GlaxoSmithKline</td>
<td>2 doses, given 6-12 months apart</td>
<td>10 years following booster*</td>
<td>Children from 1 to 15 years</td>
</tr>
<tr>
<td>Vaqta Paediatric</td>
<td>Aventis Pasteur MSD</td>
<td>2 doses, given 6-12 months apart</td>
<td>10 years following booster*</td>
<td>Children form 2 to 15 years</td>
</tr>
</tbody>
</table>

It is good practice to continue a course of hepatitis A with the same brand of vaccine. However, evidence suggests that hepatitis A vaccines are likely to be compatible with each other, and if necessary a different brand of hepatitis A vaccine could be given.

*There is no evidence that further reinforcing doses of hepatitis A vaccine are needed in immunocompetent individuals following the completion of the primary course. However, further advice should be sought for individuals with altered immune responses.
Interrupted Courses

The SPC states that for Havrix Monodose and Havrix Junior Monodose, a booster that is delayed for up to 3 years can be expected to induce similar antibody levels as a booster given within the recommended 6-12 months.

The SPC states that for Avaxim the reinforcing dose may be administered up to 36 months after the primary immunisation.

Vaqta Paediatric booster doses can be administered up to 18 months following the primary dose.

Booster doses delayed beyond the recommended interval are not covered by the Product Licence. However, research suggests that reinforcing doses of Havrix Monodose and Junior Monodose given up to 66 months after the first dose will still boost the primary dose, i.e. immunity is expected to persist for at least 10 years.\(^6\)

Good protective antibody levels are achieved even if the booster dose of Epaxal is given up to 56 months after the primary dose.\(^7\)

Contraindications

- Current severe febrile illness
- Individuals who develop symptoms suggestive of hypersensitivity after vaccination should not receive further doses

  Specifically to Epaxal
  - Hypersensitivity to eggs and chicken protein

Adverse events

Adverse reactions following hepatitis A vaccine tend to be mild and transient. They include tenderness, redness and swelling at the injection site. Less commonly, fever, headaches, dizziness and malaise have been reported.
References

1. CDC. Hepatitis A amongst homosexual men. MMWR 1992;41:155 pp161-4


