Catch-up immunisations and funding rules

Dear Editor,
It's good to be reminded that immunisations are not just for kids in Issue 49 of BPJ (Dec, 2012), yet it would be helpful to clarify funding for adult catch ups as even in this journal (Page 7) we are assured that there are funded adult catch-ups yet (on Page 37) you state that adults must pay for catch-ups themselves. My understanding is that funding is available to pay for a primary course of certain vaccines as per page 21 and the back cover of the current Immunisations Handbook.

To be able to fund catch-ups for the over age 18s is reassuring as we know those people who have had a primary course of tetanus have good protection. I never quite understood why the age 45 and 65 tetanus booster vaccine is funded but not the administration, i.e. no fee is claimable for the nurse's time.

Finally I wish it were true that (as per page 37) females age 20 could be caught up for HPV. I think the funding rules are that they must have commenced dose one before their 20th birthday.

***Barbara Warren**, Practice Nurse*
Dunedin

It is correct that certain vaccinations are available, fully funded, for adults who have never had a course of vaccinations, and have not been exposed to the condition being vaccinated against. There are three vaccines in this category that are available to anyone, at any age: Td (tetanus/diphtheria), MMR (measles, mumps and rubella) and IPV (polio). The funding includes the Immunisation Benefit Subsidy to cover the cost of delivery. The funding for the age 45 and 65 year Td booster is different in that, unlike other vaccines, the dose is funded, but the cost of administration (Immunisation Benefit Subsidy) is not. The reason for this is largely historical. So in summary, if the Td is being given as a primary course, not a booster dose, then the Immunisation Benefit Subsidy can be claimed.

Some other vaccinations are funded for adults in certain scenarios, such as people pre- or post splenectomy (HiB, Meningococcal A, C, Y and W135 and pneumococcal polysaccharide vaccines), people who are household or sexual contacts of Hepatitis B carriers and Tdap vaccine for women who are pregnant. In addition, influenza vaccination is funded for people aged over 65 years, women who are pregnant and those with a chronic condition outlined within the New Zealand Immunisation Handbook (although funding rules are subject to change).

Other vaccines that may be useful to adults and should be considered, but are not funded, include varicella for those without a history of chicken pox and pneumococcal vaccines for those with chronic chest conditions.

Women have until their 20th birthday to begin the HPV immunisation programme. This means that the first dose must be delivered prior to their twentieth birthday, but subsequent doses may be given beyond this age.

Recommended vaccinations for staff working in primary care

In Table 1 in the article "Recommended vaccinations for staff working in primary care" (BPJ 49; Dec, 2012), some of the table notations were incorrectly labelled. This inadvertently occurred when reproducing the table. The notations have now been corrected in the online version of this article, available from: www.bpac.org.nz

The original table is also available from: **www.immune.org.nz**

ESR and burning feet

Dear Editor,
With regard to your sidebar "burning feet syndrome", within the article "The night time hustle: managing restless legs syndrome in adults", BPJ 49 (Dec, 2012), you mention ESR as an appropriate test for multiple myeloma.

I am curious about this as our regional laboratory, in conjunction with the consultant Haematologists at Palmerston North Hospital, circulated a memo in April, 2010, stating that ESR would not be done for any indication other than Systemic lupus erythematosus, Rheumatoid Arthritis, Kawasaki Disease, Rheumatic Fever and Hodgkin's Lymphoma. They stated that ESR is not an appropriate test in multiple myeloma because of its lack of specificity and quality assurance.

I wonder if this is the case throughout New Zealand, or a local situation?

***Dr. Marion Taylor**, General Practitioner*
Wanganui

In the "burning feet" sidebar of the article you refer to, ESR was suggested as an investigation that may be considered, along with serum protein electrophoresis and serum free light chains or Bence Jones protein in urine to rule out the possibility of multiple myeloma in a patient with burning feet (and other reasons to suspect multiple myeloma as a cause). We agree that ESR alone is not useful for diagnosing multiple myeloma as it lacks specificity - while ESR is usually elevated in people with multiple myeloma when CRP is normal, there are many other potential causes of a very high ESR. This approach to investigating possible multiple myeloma (i.e. ESR + other tests) is recommended in the British guideline for multiple myeloma,[1] and in other literature.[2]

However, after consultation with several laboratories and haematologists it appears that the growing consensus in New Zealand is that measurement of ESR is no longer recommended when investigating possible multiple myeloma. A practical approach, if myeloma is suspected, is to first request serum protein electrophoresis. If an increase in immunoglobulins is found, or the test is normal but clinical suspicion remains, the need for further testing (e.g. serum free light chains or Bence Jones protein) should be discussed with a haematologist or other relevant specialist.

National laboratory testing guidelines are currently in development, and it is likely that serum free light chains will be one of several tests that are recommended for restricted use. We will provide an update on these guidelines when they become available.

References

1. Bird J, Owen R, D'sa S, Et al. Guidelines for the diagnosis and management of multiple myeloma 2011. Brit J Haematol. 2011;154(1):32–75.
2. Watson J, Round A, Hamilton W. Raised inflammatory markers. BMJ. 2012;344:e454.

Fasting requirements for blood tests

Dear Editor,
I have been taking fasting bloods from patients for a long time now and have been telling patients that they should fast for twelve hours but that they can have water or black tea or coffee. I thought this was common practice until I received a letter from the laboratory, stating that tea and coffee should not be consumed during the fasting period as caffeine can affect glucose levels.

I would like to know what the research has shown regarding fasting status in lipid and glucose test results (not that a fasting glucose is used very often now). It would be great if everyone in primary health care was treating fasting bloods in the same manner.

***Helen Homan**, Practice Nurse*
Dunedin

Recommendations for the length of a fasting period for glucose and lipid tests vary between laboratories. The accepted minimum fasting time is eight hours,[1] but twelve hours is preferable.

Water may be drunk during the fasting period, but tea and coffee (even without milk) should not be consumed. Caffeine

can temporarily produce a small, but detectable, transient increase in serum glucose levels (approximately 10%).[2] The reason for the increase is not well understood, as overall insulin sensitivity is not affected by caffeine.[2] It is likely that the effect comes from either increased bioavailability of glucose or from a relative effect on insulin secretion. The effect of caffeine on lipid levels is less significant and is unlikely to alter fasting blood test results (unless milk or cream is also added).[3] However, to avoid confusion, it may be best to advise patients not to drink tea or coffee during a fasting period for any fasting blood test.

HbA_{1c} is recommended in preference to fasting glucose for investigating diabetes in most people, as, among other reasons, the requirements of a fasting glucose test are a significant burden to many patients.

There is increasing debate as to whether a non-fasting lipid test is adequate for a cardiovascular risk assessment. Patient compliance is likely to be higher if a lipid test can be performed "now", rather than asking the patient to fast and present at a laboratory in the morning. However, current cardiovascular risk assessment guidelines are based on fasting test results.

We hope to follow this debate and update this issue in the future.

For further information on the use of fasting glucose see: "When to use a fasting glucose to diagnose type II diabetes", Best Tests December (Dec, 2012).

References

1. Editor: Kyle C. A handbook for the interpretation of laboratory tests. 4th ed. Diagnostic Medlab; 2008.
2. Krebs JD, Parry-Strong A, Weatherall M, Et al. A cross-over study of the acute effects of espresso coffee on glucose tolerance and insulin sensitivity in people with type 2 diabetes mellitus. Metabolism 2012;61(9):1231–7.
3. Zargar A, Auttapibarn C, Hee Hong S, Et al. The effect of acute café latte ingestion on fasting serum lipid levels in healthy individuals. J Clin Lipidol 2012;In press, corrected proof.

We value your feedback. Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz