Vaccine shortage

The MPA is aware of, and has received feedback from Paediatricians nationwide regarding, the shortage of the primary vaccines. We have also received emails asking about what steps MPA is taking to help solve this problem. Private General Practitioners who give vaccinations are also affected. In fact, at the Asia Pacific level, other private practitioners in other countries especially the South Asian countries have also complained of vaccine shortages. So it is not a local problem!

The vaccines involved

The shortage first started with the optional varicella vaccine because a company producing this vaccine decided it was not viable to continue. Then the quadrivalent measles, mumps, rubella, varicella (MMRV) vaccine disappeared from the market resulting in a temporary shortage of MMR vaccines too. The varicella vaccine is currently available in limited supply by one company (MSD) while MMR vaccines returned.

As if that was not enough, the primary DTaP vaccine started disappearing from the market. The hexavalent DTaP/IPV/Hib/HB produced by GSK (Infanrix Hexa) and Sanofi Pasteur (Hexaxim) were not accessible in the beginning and has remained unavailable. The primary pentavalent DTaP/Hib/IPV by both companies then became scarce. The shortage of these vaccines affected only the private market of Paediatricians and GPs.

The reasons

The problem is with the production of these vaccines by the manufacturers. There was a problem with production of the primary pentavalent vaccine by a major manufacturer resulting in a shortfall in supply. Priority had to be given to the National Immunisation Program (NIP) and those already committed. Hence, all the vaccine supply went to our Ministry of Health for the pentavalent DTaP/IPV/Hib vaccines. The MMR vaccine has ramped up its production so it is available but there is still a shortage of varicella vaccine with only one supplier at the moment. Competition for the vaccines within the region added to the shortfall. These vaccines naturally ended up in countries where they cost more. As Malaysia was getting the vaccines at rates lower than our neighbours, the priority was obvious.

Short-term solution

There have been requests by Paediatricians for MPA to take proactive measures to prevent vaccine shortages from happening. As this is an issue of production, the solution lies with the manufacturers, not with MPA. Short of stockpiling in anticipation of another shortage, there is nothing much that MPA could do. Stockpiling would be an expensive and counter-productive response by MPA. We have had continued on page 3...
Lessons Learnt as President

Dear friends and colleagues,

What a relief, I survived the 2-year term as President. Allow me to share some lessons learned and some wishes for MPA.

In the beginning, there were enthusiasm, ideas and plans. One would want to make things different. However I realised that it took more than enthusiasm and drive to make things different. Certain issues may take more than 2 years to change. I also realised that there were many things that I did not know. I learned a lot from the Exco members and at least at all times we decide as a team after a good exchange and discussion. I learn more about organizing conferences, relations with the Ministry and authorities, with the pharmaceutical & nutritional industries, ethical and public issues, the media and the press. However, unfortunately I am not in the “movers or shakers” group.

More pending issues

There are still many issues that need our attention. We need more of our members to be directly involved in subcommittees, expert groups and in advocacy. It is always the same voices that make their noise heard or dare to speak. I am sure there are talents out there. There are people with burning desires to make a difference in our children’s well being. Please make yourselves heard to us.

I would encourage the Paediatric Nurses group who are associate members to strengthen and organize themselves as a recognizable profession. I consider the Paediatric Nurses as our partners in child health and the pillar of good quality care and an extension of our management. You must rise to be recognized, noticed and be one of our advocates for quality care.

Better governance

My greater wish is to see better governance, and complete implementation of government policies for a more comprehensive child education, inclusive healthcare reforms and strengthening values and culture in positive parenting and childcare for all.

Lastly I wish to thank all my Exco members for giving me all the support and the harmony we kept in the meetings and most of all the ever hardworking and efficient Secretary, Prof Tang Swee Fong. My thanks also goes to Datin Saadiah Ahmad, and her team for keeping us “filled up” during our Sunday morning meetings.

I welcome the President Elect, Dr Thiyagar to the President’s chair for the next 2 years and continue to lead us for the better and into the future.

I again extend our invitation to all to attend our 37th Annual Congress organized with the Asia Pacific Vaccinology update focusing on Pneumonia and Diarrhoea at the Shangri La Hotel KL.

Kok Chin Leong
President 2013-2015
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... from page 1

discussions with the different companies and we give their feedback in the ensuing pages.

What we can do as Paediatricians in private practice is to refer or divert our patients who require the primary pentavalent vaccines to the Klinik Kesihatan (KK) or Health Clinic nearest their homes. The KK staff should not refuse these patients even though they are not delivered at MOH facilities (this was clarified after a meeting with MOH). Some privileged private practices have managed to get the pentavalent vaccine with short expiry dates. The hexavalent vaccine looks like it is not likely to make a comeback until the end of the year, and possibly beyond. As MMR is still available in limited quantities, these can still be given by private practitioners. With regard to varicella vaccines, MSD is able to bring limited volumes of the monovalent varicella vaccines (Varivax) for our use.

What’s left for private sector?

The vaccines that are still available to private practitioners will be MMR, varicella, pneumococcal, rotavirus, influenza, hepatitis A and meningococcal ACWY vaccines.

We have to make the best of the current situation and ensure that our patients get their primary vaccinations as in the NIP from the nearest KK. They can be told to get the other recommended vaccines from the private sector.

Zulkifli Ismail
drzulkifli.ismail@gmail.com
For the Executive Committee

15th October 2014

Dear Valued Customer,

Supply Constraints of GSK Vaccines

As one of our valued customers, we deeply regret to inform you that GSK is experiencing global challenges in our production capacity for the vaccines below which will significantly affect supply throughout 2015.

However, for Infanrix Hexa and Priorix, supply constraints are temporary with supply expected to resume by the first quarter of 2015.

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Estimated out-of-stock date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Infanrix® IPV-HS Combined diphtheria-tetanus-acellular pertussis, inactivated polio</td>
<td>October 2014</td>
</tr>
<tr>
<td>2 Infanrix® Hexa Combined diphtheria-tetanus-acellular pertussis, hepatitis B, enhanced inactivated polio vaccine and Haemophilus influenzae type b vaccine</td>
<td>November 2014 (temporarily out-of-stock)</td>
</tr>
<tr>
<td>3 Priorix® Measles, mumps, rubella (live, attenuated)†</td>
<td>November 2014 (temporarily out-of-stock)</td>
</tr>
<tr>
<td>4 Havrix® 720 Junior Inactivated hepatitis A vaccine</td>
<td>January 2015</td>
</tr>
<tr>
<td>5 Havrix® 1440 Adult Inactivated hepatitis A vaccine</td>
<td>January 2015</td>
</tr>
<tr>
<td>6 Hiberix® Haemophilus influenzae type b (Hib) vaccine</td>
<td>June 2015</td>
</tr>
<tr>
<td>7 Infanrix® IPV Combined diphtheria-tetanus-acellular pertussis and inactivated polio</td>
<td>June 2015</td>
</tr>
<tr>
<td>8 Varilrix® varicella vaccine (live, attenuated)</td>
<td>Currently out of stock</td>
</tr>
<tr>
<td>9 Priorix® Tetra Measles, mumps, rubella and varicella vaccine (live, attenuated)</td>
<td>Currently out of stock</td>
</tr>
<tr>
<td>10 Typherix® Vi polysaccharide typhoid vaccine</td>
<td>Currently out of stock</td>
</tr>
</tbody>
</table>

† this out-of-stock situation is only applicable to the private sector

GSK understands that this is unwelcome news and is committed to restoring manufacturing capacity to normal to minimise disruption as soon as possible.

This supply constraint is not related to quality or safety issues with these vaccines. GSK has every confidence in the quality of its vaccines and is committed to maintaining the highest standards of vaccines quality and meeting all expectations related to Good Manufacturing Practices.

Zulkifli Ismail
Dr Zulkifli Ismail
For the Executive Committee
Potential Supply Shortfall of Acellular Pertussis Combined Vaccines

FAQ from Sanofi Pasteur

Q1 – Why is supply constrained?

SP: The manufacturing operations performed to produce and distribute the AcXim products are among the most complex of the vaccine industry as they encompass multiple and successive operations to be executed in order to manufacture ten different Drug Substances (the antigens or their components) and the aluminium adjuvant gels and then to manufacture 3 different Drug Products (the vaccines).

These 3 Drug Products are in turn filled, labelled and packaged in a multitude of final presentations (single-dose vials or syringes, single- or multi-container box with a multitude of country-specific labelling documents).

Each raw material (dozens), each Drug Substance (and all of their intermediates), and each Drug Product are tested by a battery of in vitro and in vivo assays to allow the next manufacturing step to proceed, resulting in a total of hundreds of tests done over the entire set of manufacturing steps for every batch of final product to be shipped to customers.

These quality control tests are often initiated at risk (next manufacturing step already engaged) and many of them (the in vivo assays) are suffering from high sensitivity to execution variations inducing high rates of invalid assay runs.

As a result, the total cycle time for all these products are roughly 18 to 24 months, and the customer and regulatory constraint attached to all product batches are making extremely difficult any decision to re-allocate one batch of a given product from one market to another, particularly for those well engaged in their last manufacturing steps (filling, packaging and labelling). It has to be known that each manufacturing step and each QC test might experience technical difficulties making the decision to proceed to the next step delayed (or even cancelled if a decision to not use the intermediate product under analysis is taken).

In addition, and as expected for this kind of products, a multitude of Chemistry, Manufacturing and Control modifications are constantly ongoing to introduce improvements to the manufacturing (equipment and / or processes) and quality control (assays, equipment, reagents, standards) steps of these raw materials (the Drug Substances and the adjuvant), Drug Products, and finished products.

It can therefore be understood the extreme complexities for vaccine manufacturers to manage delivery of products aligned with their regulatory status in all the countries where these products are marketed.

As the global demand for aP-backboned products is surging in 2015 and in the subsequent years, depending on countries, either the quantities of finished products that will be delivered will be decreased and / or the supply dates will be delayed for variable periods. This will create in some countries (or in some regions within countries or at some point of vaccination within regions) out-of-stock (OOS) events that will last for variable periods.

Q2 – Are these production issues linked to a vaccine safety issue?

SP: It is important to note that all pediatric acellular-pertussis (aP) containing combination vaccine doses currently on the market meet all approved safety and quality standards requirements.

Q3 – What is the impact?

SP: The current supply plan that vaccine manufacturers has estimated / projected is not sufficient to fully satisfy the global market needs that have been requested of it. The long lead times to produce these combination vaccines will prevent vaccine manufacturers from significantly increasing supply in the short term.

In countries where there will be a shortfall / shortage, vaccine manufacturers are working to meet public health needs as best as possible to ensure continuation of public vaccination programs in those countries.

Q4 – When will you be able to come back to a normal supply situation?

SP: The long lead times to produce these combination vaccines will prevent vaccine manufacturers from significantly increasing supply in the short term. However SP is doing its best to ensure supply resumes to normal in the near future.

Q5 – How long does it take to produce these vaccines?

SP: Production cycle of the pertussis containing combination vaccines takes 18 to 24 months.
Q6 – What is the recommendation in the situation where a child who has received a birth and 1st month dose of Hep B monovalent vaccine be given a hexavalent combination vaccine in primary series and/or booster immunisation?

SP: It is always preferable to follow recommended schedule for Hepatitis B vaccination. In this regard, both WHO and CDC say that for programmatic reasons, it is acceptable to use 4 doses of Hepatitis B in the primary series - the 1st dose as Hepatitis B at birth and then the next 3 doses as part of a combination regimen.

Nevertheless, based on principles of vaccination, extra doses of Hepatitis B are not necessarily seen as detrimental, rather they can even boost the response to Hepatitis B. In fact, for Hepatitis B non-responders or for those who are immunocompromised, regimens using double doses or repeated series are often used. Thus, the schedule of Hepatitis B at 0 and 1, followed by 3 hexavalent doses for primary series, would not be a practice that we would advocate routinely, but would still be accepted as valid.

Q8 – Interchangeability between pediatric acellular-pertussis (aP) containing combination vaccines in primary series?

SP: In general, we encourage vaccine users who have started with a particular brand to complete the series with the same brand for the primary series. Nevertheless, if the previously administered vaccine is not known or not available, then any licensed DTaP containing vaccine may be used to complete the primary series according to the recommended schedule.

Q7 – What is the recommendation in the situation where primary immunisation is not able to be completed with the same product?

SP: In a situation where it is impossible to complete the vaccination regimen with the same product, as recommended by several National Immunization Policy Committees and WHO, infants should receive time-appropriate vaccinations with any available DTP, Hib and IPV containing combination vaccines to complete the series.

Vaccination should not be deferred and should be performed within the licensed time intervals because the brand used for previous doses is not available.

Q9 – What is the recommendation when primary or booster dose cannot be given at the recommended time according to the schedule and need to be postponed?

SP: Prescribers should refer to their national official recommendations.

In infants who have not yet received their doses of the 3-dose infant series, the objective would be to start the infant series as soon as possible and at an age as close as possible to the recommended age.

Starting infant primary series at an age older than 3 months has not been pro-actively documented in all pre- and post-licensure clinical trials, but one might easily understand that starting regimen later will always be better than not vaccinating at all.

Q10 – What is the recommendation if there is no supply available to ensure timely completion of the series according to the recommended immunization schedule?

SP: Prescribers should refer to their national official recommendations.

As a principal, all efforts should be made to ensure that a child receives the appropriate primary and booster vaccination in a timely manner.

In a situation where it is impossible to complete the vaccination regimen within time-appropriate vaccination windows, infants should receive vaccination as close as possible to time-appropriate vaccinations with any available DTP, Hib and IPV containing combination vaccines to complete the series. An interruption in the vaccination schedule does not require restarting the entire series of a vaccine or addition of extra doses.

Q11 – How long can a vaccination be delayed?

SP: Vaccination should not be deferred because the brand used for previous doses is not available and should be performed within the licensed time intervals. Longer intervals (>2 month) have not been pro-actively documented in pre- and post-licensure clinical trials. but one might easily understand that giving the dose later will always be better than not vaccinating at all. 

SP: In a situation where it is impossible to complete the vaccination regimen with the same product, as recommended by several National Immunization
Nurses’ Day is celebrated on 12th May every year. KPJ Damansara Specialist Hospital (DSH) and KPJ Selangor Specialist Hospital (SMC) organised a Nurses’ Day Symposium in collaboration with the MPA at the newly refurbished Sutera Conference Room in DSH. Opened to a limited number of staff nurses from private, government and university hospitals around the Klang Valley, it attracted about 100 nurses. The whole organisation of the symposium was done by the nurses from these two hospitals with the guidance of two paediatricians, Dato Dr Musa Mohd Nordin and Datuk Dr Zulkifli Ismail representing their own hospitals and MPA. Managing to get ten companies to sponsor this one day event, emails were sent to all the hospitals in the list to get the names of nurses to attend. 

After short welcome speeches by the Chief Nursing Officer of DSH, Cik Jaliah Mat Jani, and the Medical Director, Dato Dr Azizi Omar, the show began with the first plenary on Evidence-Based Nursing Practice by Dr Aini binti Ahmad, a senior lecturer from the Open University Malaysia. She advocated evidence-based practice (EBP) over the old one based on tradition and personal experience. EBP resulted in a multitude of improved health, safety and cost outcomes, including a decrease in patient morbidity and mortality. It also provides opportunities for nursing care to be more individualized, more effective, streamlined and dynamic, and to maximize effects of clinical judgement.

Dato Dr Azizi then gave his charismatic talk on medical errors and patient safety by saying that anesthetists were the first to look at safety in healthcare. He quoted many books and articles, the most notable of which were the 6 aims of improvement in quality taken from the Institute of Medicine publication ‘Crossing the Quality Chasm’ 2001 : Safety, Patient-centredness, Efficient, Effectiveness, Timeliness and Equity. He also quoted two additional attributes of Access to Care and Care Coordination. His memorable quote at the end was “You can spread death by not washing hands!”
Free paper presentations

There were six free paper presentations from nurses in the two hospitals. The topics ranged from a complex neurological case report through nursing education, innovative ways to encourage influenza vaccination uptake to environmental surface cleaning. The winner was about knowledge of urinary incontinence and pelvic floor muscle exercises among nulliparous pregnant women by SN Parwathi Alagirisamy from DSH.

More entertaining talk

Just when the participants thought they had heard a good lecture from Dr Azizi, out came Dame Hajah Ramziah Hj Ahmad, Past President of the Malaysian Nursing Association (MNA) who gave an eloquent, entertaining and amusing talk on Stress among Nurses. She got everybody in stitches with her antics and anecdotes that were laced with teaching points. The take-home message from her talk was that we have to recognize the stressors and deal with them accordingly, and that one has to be in control of one’s own stress to cope with it. It was a lively talk that had the audience clapping and laughing.

A lawyer, Puan Maidzuara Mohammed from Raja, Daryl & Loh Advocates & Solicitors then gave an overview of medico-legal exposure for nurses. She went into detail on the nurses’ legal obligations when called and praised the nursing records as being more informative than the doctors’, a fact that we all know.

A light session on grooming and nursing career path given by Puan Wan Rusliah Md Daud from KPJ International College of Nursing & Health Sciences, Penang followed the lunch talk on HPV vaccination by Dato Dr Musa Mohd Nordin. Facing women in the crowd, Dr Musa convincingly talked about the human papilloma virus incidence and the usefulness of the vaccine.

Another hard talk!

As nobody is expected to be able to listen to another didactic lecture at 3:30pm, a Hard Talk forum was held to keep people awake. Moderated by Datuk Dr Zulkifli Ismail, the topic was Nurse-Doctor Partnership - Establishing Clinical Collaboration. The panellists were Dr Jeyabalan Velayutham, Nephrologist, Puan Zaharah Osman, KPJ CEO and former nurse, and SRN Adi Abadi Azahar, a male nurse from DSH. The discussion centered on mutual respect, professionalism, clear communication, knowing oneself and correcting attitude problems. Generational comparisons between the current Gen Y and the baby boomers were also made with little response from the former. Surgeons’ temper tantrums in the operating theatre suites were also brought up by the participants resulting in a response from the sole orthopedic surgeon in the crowd, Dr Rosman. Although entertaining, the session helped open up a discussion on issues between the two professionals that will hopefully leave both groups more understanding of the other.

The symposium was an eye-opener for both the nurses and the doctors and helped encourage more confidence among the new and younger nurses. It is hoped that this exposure will help mature our nurses to allow them to speak up and communicate better, and for the doctors to better understand their co-workers. A vote of thanks to the committee of nurses from both hospitals for pulling off this event in a short period of time with support from the management of DSH. They are now eager, raring and confident enough to organise the nursing symposium at our MPA Congress in 2016!

Zulkifli Ismail
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The Pediatric Infectious Disease Society of Thailand (PIDST) was formed on 24 January 1995. This year it celebrates 20 years of influential existence by having an annual congress with the involvement of ASEAN Paediatric leaders in vaccine advocacy and research. A workshop on National Immunisation Program and Vaccine Coverage in ASEAN countries was organised on 30th April 2015 before the start of the 19th Annual Meeting of PIDST. The venue was the prestigious Royal Cliff Hotels in Pattaya.

WHO keynote speaker

The keynote speaker was Dr Jean-Marie Okwo-Bele, WHO Director of Immunization, Vaccines and Biologicals, Family, Women’s & Children’s Health based in Geneva. He talked about the Global Vaccine Action Plan (GVAP) 2011-2020. He also elaborated on maternal vaccines, the current recommendations being tetanus, influenza and pertussis in the cocoon theory to protect newborns. Early stages of development involve Respiratory Syncytial Virus (RSV) and Group B Streptococcus (GBS) vaccines. He reminded the audience that maternal and neonatal tetanus has been eliminated in 36 countries in 2000-2015, leaving 23 countries still having neonatal tetanus.

The flagship of adolescent vaccines is of course human papilloma virus (HPV) vaccine. The uptake by countries has been slow. Others include Td and MR boosters.

WHO request

He ended by stating what WHO requests of paediatricians - ensure patients are fully immunized, travelers are advised appropriately, advocacy role with government officials, and contribute to surveillance activities.

This keynote was followed by reports of the National Immunisation Programs and Vaccine Coverage in ASEAN countries starting with Cambodia (certified measles free in 2015 with no measles cases from 2011), followed by Indonesia, Malaysia, Myanmar, Philippines, Singapore, Thailand, Vietnam and Laos.

Best of six

After lunch were six oral presentations judged by seven judges from different ASEAN countries. The high quality presentations were hard to judge and the marks were very close. The winner was Dr Terapong Tantawichien et al with their presentation on immunogenicity of new single-visit booster regimens for rabies post-exposure prophylaxis in pre-immunized individuals. Other oral presentations involved varicella zoster, pharmacokinetics and pharmacodynamics of vancomycin, influenza and RSV diagnostic kits, rabies-free zone at Lat Krabang district in Bangkok and vaccination coverage in metropolitan Bangkok, all of which were interesting. There were also many poster presentations.
The informal Faculty Night was at the Panorama Restaurant in the same hotel complex starting at sunset and ending with entertainment by each of the participating countries.

Simple yet elegant opening

The next day was the opening ceremony with entertainment by a group of talented young musicians from Dr. Sax Chamber Orchestra belting out a soprano and a medley of popular songs. Prof Usa Thisyakorn gave the most concise talk on what’s new in dengue in 20 minutes followed by Prof Tikki Pang on the policy issues related to the dengue vaccine.

The remaining days of the meeting were in the Thai language. The 500+ delegates definitely enjoyed the scientific discourse and social interactions.

We congratulate PIDST and its committees on its 20 years of unsurpassed excellence and influence in promoting infectious disease research, treatment, control and prevention.

Zulkifli Ismail
APPA President
drzulkifli.ismail@gmail.com

Condolences

Dr Lam Pan Nam
(18 July 1959 - 23 June 2015)
gr graduated from UM with MBBS 1985 and obtained his MRCP (UK) in 1990. He started his Paediatric GP practice in 1990 in Batu Pahat, Johor becoming the first private paediatrician in that town.

From Dr SP Chuah, Paediatrician: “I know he was very active in the early intervention centre for the handicapped in BP and helped raise much fund and was a chairman of the centre run by the Grace BP Church, his church.”

From another friend, Dr Goh Teck Leong: “The first private paediatrician in BP. Main person behind the setting up of a learning facility for handicapped and disabled children. A devoted Christian.” As the fund-raising chairman, he raised RM330,000 for the centre (The Star-on-line, Friday Sept 26, 2008).

He will not only be missed by his family members, but also by the Batu Pahat community especially the Down syndrome and disabled children, for whom he devoted so much of his time and energy. The MPA sends our condolences to his wife and 3 daughters, and granddaughter.
We had recently concluded our diabetes camp, which was held in “Lost World of Tambun” Ipoh, on 1st to 3rd June 2015. Diabetes camp has always been a much-awaited event for children and adolescents with diabetes. It is not just a time of fun and outing, most importantly it is a time of learning, sharing and building friendship. For the doctors, nurses and the rest of the medical team, diabetes camp is an opportunity for us to share the lives of these young diabetics, empowering them with the knowledge and skills to self-manage their diabetes in their daily living. To many of us, it is also a humbling experience as we learned a lot from our young diabetics who have far greater practical experience in diabetes management than us.

A total of 35 young diabetics participated. To facilitate teaching activities, the diabetic children were grouped according to their ages ie 6-8, 9-12, 13-14 and 15-18 years. We had an exciting educational program as prepared by the Young Diabetics Support Group of UKMMC. The children learned and re-learned about hypos, hypers, carb counting, calculation of meal and correction doses of insulin, reading nutritional labels on food etc. We even had a practical session when the children learned to prepare healthy sandwiches. While the young children were having their lessons, the older group (15-18 years) had private discussions with our psychologists who helped them to gain deeper insight of themselves, uncover their hidden feelings.
and empower them to work out strategies to cope with their struggles and barriers to diabetes control.

Among the outdoor activities, the children most enjoyed the Water Park where they spent almost four hours under the adults’ supervision. Hypo kits were at hand, but none of our children had significant hypoglycaemia. Throughout the camp, each child had about 8-10 finger-pricks per day to monitor their blood glucose to ensure the levels are within acceptable limits. The children learned through camp experiences the effects of prolonged/strenuous physical activities on their blood glucose and appropriate measures to prevent or treat hypoglycaemia during and for many hours after such physical activities.

The highlight of the camp was on the last day when there was prize giving for all the competitions and activities followed with the grand finale of a talent-time when each group of children would perform a skid. The youngest group (6-8 years old) emerged champion for their spontaneity and creativity. It is so encouraging to see these children being able to live an active life just like any other normal kids, despite their diabetes. With incessant education and guidance, we believe the diabetic children “BOLEH”. This is evident by the high standard of blood glucose control in many of them during the camp despite unceasing activities. The winner of the “best glucose control” in each of the age-group had scored an average blood glucose value of 10.6 mmol/L, 10.00 mmol/L, 8.2 mmol/L and 6.6 mmol/L in the 6-9, 10-12, 13-14 and 15-18 years age-group respectively. We are convinced that the camp has definitely helped the children in their knowledge, self-confidence, and emotions etc towards better self-management of their diabetes. We hope this will have a lasting impact.

The camp would not have been possible without our sponsors. We are very grateful for their continual support and contributions. Thank you.

Wu Loo Ling
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Pregnant Women Get More Ultrasounds, Without Clear Medical Need

In 2014, usage in the U.S. of the most common fetal-ultrasound procedures averaged 5.2 per delivery, up 92% from 2004, according to an analysis of data compiled for The Wall Street Journal by FAIR Health Inc., a nonprofit aggregator of insurance claims. Some women report getting scans at every doctor visit during pregnancy. This is obviously far too much!

This comes despite recommendations in the US which clearly state that women with low-risk pregnancy should, at most, undergo two ultrasounds one around the 20th week and another earlier one, around the 12th week.

Research should be kept up-to-date

The benefits of ultrasounds are proven:
1. Provides an accurate estimate of when conception begins.
2. Helps doctors determine when to induce labor and when a pregnancy has gone on too long.
3. Identify multiple fetuses and detect abnormalities that elevate a pregnancy’s risk level.
4. In high-risk pregnancies, additional scans are often crucial.
5. Images of the unborn can help foster bonding, perhaps persuading some pregnant women to quit smoking.

Similarly, fetal ultrasound in humans has never been shown to cause harm. But nearly all research supporting its safety was conducted using equipment made before 1992, when the FDA raised the allowable fetal-ultrasound output to 720 milliwatts per square centimeter—a measurement of acoustic energy and intensity—from the previous 94.

The increase was decided because under previous constraints, the obesity epidemic was making it difficult to gain clear images of some fetuses. Obstetricians also argued that clearer images would enable more-accurate findings from the procedure. However, major epidemiological studies haven’t been done since then on fetal ultrasound, there are some unknowns about long-term effects of modern equipment.

What’s the drive?

Doctors

It’s speculated that the rising usage rates in part reflect a belief among obstetricians that routine peeks at the fetus can stave off surprises. Obstetrics pays among the highest malpractice premiums of any medical specialty, and experts in the field say it isn’t uncommon for lawsuits against obstetricians to allege that more ultrasounds should have been performed. Some experts may also see financial motives behind frequent ultrasounds, which can be quite costly and can represent significant revenue for them.

Technicians

Additionally, when the FDA raised power limits, it required equipment to display two safety indexes:
- Thermal index (TI): indicates potential for rising temperature.
- Mechanical index (MI): indicates the potential for mechanical effects that could pose risks to tissue and cells.

Sonographers would then use this as a guideline to provide safe and accurate service to the patient. Regrettably, studies have found that most fetal-ultrasound operators pay little attention to the TI or MI when conducting the procedure.

Parents

Another contributing factor are parents themselves. Ultrasound has a unique appeal for parents. Offering a magical glimpse inside the womb and many long to see their unborn at every doctor’s visit. Moreover, the trend of posting fetal images on social media has become a new rite, and obstetricians’ websites increasingly are decorated with fetal images.

The consequence of bliss

Studies show that multiple fetal ultrasounds can raise false alarms like the overestimation of fetal size that can lead to potentially unnecessary cesarean deliveries. Research also suggests multiple scans don’t provide better outcomes in pregnancies.

Furthermore, a study published last year in the journal Autism Research found that mice exposed to ultrasound in utero exhibited hyperactivity and social deficits in the presence of other mice. And, in 2009 the International Journal of Developmental Neuroscience published research which found that fetal chicks exposed in eggs to ultrasound demonstrated post-birth learning and memory deficits.

A need for change & collective action

Frequent fetal-ultrasounds in low-risk pregnancies aren’t medically justified. A joint statement in May 2014 from several medical societies, including the American College of Obstetricians and Gynecologists, calls for one or two ultrasounds in low-risk, complication-free pregnancies. Understand that about 80% of pregnancies are low-risk.

Moreover, ultrasound should be used only when clinically indicated, for the shortest amount of time and with the lowest level of acoustic energy compatible with an accurate diagnosis. The public needs to be made aware that if you’re pregnant, not only should you not drink alcohol, you also shouldn’t smoke and you definitely don’t need to have an ultrasound at every doctor’s visit.

Kevin Hellliker
Editor, Wall Street Journal
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BREASTFEEDING

5 Steps to Make it Work

Breast milk is the best milk for babies as it is the most natural source of nutrition for baby. Here are five steps to help you have a successful breastfeeding journey.

1. PREGNANCY: PLAN AHEAD

- Be mentally prepared
- Learn more about breastfeeding
- Get support from your loved ones

2. AT BIRTH: START IMMEDIATELY

- Make skin-to-skin contact with your baby
- Breastfeed your baby within the first hour of birth

3. AFTER BIRTH: PRACTISE EVERYDAY

- Practise proper latching
- Breastfeed your baby exclusively and on demand
- Get enough rest and eat nutritious food

4. BEFORE RETURNING TO WORK: EXPRESS AND STOCK UP

- Practise expressing milk before maternity leave ends and start stocking up
- Get your baby to accept expressed milk
- Express every three to four hours and store appropriately

5. GET YOUR EMPLOYER’S SUPPORT

- Request for flexible working hours/breaks for expressing
- Ask for a clean and comfortable place/room to express and a proper storage space (eg. refrigerator)
- Get support from co-workers

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www.mypositiveparenting.org
**Local Venues**

### 37th MPA Congress & Asia Pacific Vaccinology Update

**Theme:** “Focus on Pneumonia & Diarrhoea”
**Date:** 16-19 September 2015
**Venue:** Shangri-La Hotel, Kuala Lumpur
**Tel:** 603-2698 9966, 603-2691 5379
**Fax:** 603-2691 3446
**Email:** mpaeds@gmail.com
**Website:** www.mpaweb.org.my

### Klang Valley Paediatric Cardiology Grand Rounds

**Date:** 11 September 2015
**Venue:** Auditorium, UN
**Tel:** 03-2617 8317 (Ms Nisak)/ 03-2617 8470 (Ms Haslina)
**Email:** pchcevent@ijn.com.my

### Paediatric Diabetes Education Day

**Date:** 19-20 September 2015
**Venue:** Auditorium TJ Danaraj, 3rd Floor, Faculty of Medicine University Malaya
**Tel:** 03-7949 2065
**Email:** nushadia81@gmail.com (Dr Nurshadia)

### Neonatal Update 2015 “The Science of Newborn Care”

**Date:** 30 Nov – 4 Dec, 2015
**Venue:** BMA House, London, England
**Website:** http://symposia.org.uk/neonatal/main.asp
**Email:** sympreg@imperial.ac.uk
**Tel:** +44 (0) 20 7594 2150
**Fax:** +44 (0) 20 7594 2155

### 15th APCP and Pedicon 2016

**Date:** 21-24 Jan 2016
**Venue:** Hyderabad, India
**Email:** secretariat@apcppedicon2016.in
**Website:** www.apcppedicon2016.in

### 2nd International Neonatology Association Conference (INAC 2016)

**Date:** 5-17 July 2016
**Venue:** Vienna, Austria from 15-17 July, 2016
**Tel:** +41 22 5330 948
**Fax:** +41 22 5802 953
**Website:** www.worldneonatology.com

**NEW LIFE MEMBERS**

- Dr Hasaruddin Ridzal Hanafi
  Department of Paediatrics
  Hospital Kemaman
  Jalan Da Omar
  24000 Chukai
  Terengganu

- Dr Florence Wong
  1, Jalan SS 25/39A
  Taman Mayang
  47301 Petaling Jaya
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- Dr Cheah Wen Nee
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  08000 Sungai Petani
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- Dr Marina Md Sham
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  53100 Kuala Lumpur

- Dr Shalini Shannugam
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  51200 Kuala Lumpur

- Dr Vindhu S. Venugopal
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  46050 Petaling Jaya
  Selangor

- Dr Phang Yuk Jean
  100, Persiaran Permatra
  Taman Permatra
  35500 Bidor
  Perak

- Dr Sim Hui Ling
  201, Lorong SF
  Jalan Lapangan Terbang
  93350 Kuching
  Sarawak

**NEW ORDINARY MEMBER**

- Dr Farhana Syazwani Abdul Rahman
  2A, Lorong Wangsa 6A1, Damaisat, Wangsa Melawati
  53300 Kuala Lumpur

### International Venues

#### 14th Scientific Meeting Commonwealth Association of Pediatric Gastroenterology and Nutrition in association with ISPHAN

**Date:** 2-4 October 2015, New Delhi, India
**Venue:** The Grand New Delhi, India
**Tel:** 011 4766 1234

#### Update in Paediatric Respiratory Diseases 2015 & Paediatric Respiratory and Critical Care Workshop

**Conference Venue:** Shaw Auditorium, Postgraduate Education Centre, Prince of Wales Hospital, China
**Workshop Venue:** Li Ka Shing Medical Sciences Building, Prince of Wales Hospital, China
**Date:** 13-15 November 2015
**Tel:** 852 – 2632 2829
**Email:** pae_conferences@cuhk.edu.hk
**Website:** www.pae.cuhk.edu.hk/PRD2015

#### 9th World Congress of the World Society for Pediatric Infectious Diseases (WSPID)

**Date:** 18-21 November, 2015
**Venue:** Rio De Janeiro, Brazil
**Website:** http://wspid.kenes.com/

**Needed in Sg Petani**

Paediatrician for Amanjaya Hospital

Interested? Please call:

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Dr Tan Chiang Hooi
24 hours is all it could take to change a child’s life forever

INVASIVE MENINGOCOCCAL DISEASE

- Despite appropriate antimicrobial and optimal medical care, 9-12% of patients die (up to 40% case fatality in meningococcal sepsis)²
- 11-19% of survivors live with permanent and devastating sequelae²
  - hearing loss
  - seizure disorders
  - loss of limbs
  - brain damage
  - paralysis

Children under 5 years of age are at highest risk³

Offer your patients the option of PREVENTION

- Menactra® protects against meningococcal serogroups A, C, Y, W-135⁴
- High seroprotection and seroconversion in infants and toddlers⁵,⁶
- Well tolerated in clinical studies and real-life data⁷,⁸

REFERENCES:
3. Meniogisus Research Foundation. Available at: http://www.meningoglos.org/

TRADE NAME: Menactra®, Solution for Infection. Active Ingredient: Meningococcal Serogroups A, C, Y, W-135 Polysaccharide diphtheria conjugate. Pharmacotherapeutic Class: Meningococcus, intratetraloid polysaccharide-protein conjugate. DOSAGE FORMS AND STRENGTHS: 0.5 mL, vial containing 4 mcg each of meningococcal A, C, Y, and W-135 polysaccharides conjugated to approximately 48 mcg of diphtheria toxoid protein. NOSOLO Menactra® Meningococcal (Groups A, C, Y and W-135) Polysaccharide Diphtheria Toxoid Conjugate Vaccine is indicated for active immunization to prevent invasive meningococcal disease caused by the meningococcal serogroups A, C, Y, and W-135. Menactra® is approved for use in individuals 3 months of age. Children aged 3 through 23 months of age should receive a single dose. CONTRAINDICATIONS: Known hypersensitivity to any component of Menactra® vaccine including diphtheria toxoid, or a life-threatening reaction after previous administration of a vaccine containing similar components, are contraindications to vaccine administration. Known history of Guillain-Barré syndrome (GBS) is a contraindication to vaccine administration: Vaccinations must be postponed in case of fever or acute illness. SPECIAL PRECAUTIONS: Before administration, all appropriate precautions should be taken to prevent adverse reactions. This includes a review of the patient’s previous immunization history, the presence of any contraindications to immunization, the current health status, and history concerning possible sensitivity to the vaccine or similar vaccine. As a precautionary measure, anaphylaxis injection and other appropriate agents and equipment must be immediately available in case of anaphylaxis or serious allergic reactions. The vaccine risk versus benefit for persons at risk for meningococcal disease: Intramuscular injection must be evaluated. Intramuscularly for non-immunized persons, including infants born to mothers who were not immunized against meningococcal disease. PREGNANCY AND LACTATION: Pregnancy There are no adequate and well-controlled studies in pregnant women. Menactra® vaccine should only be given to pregnant woman if clearly needed. Consideration of the severity of the meningococcal disease, pregnancy should not preclude vaccination when the risk is clearly identified. Immunization of infants - It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Menactra® vaccine is administered to a nursing woman. UNDESIRABLE EFFECTS: The following adverse events have been reported during post-approval use of Menactra® vaccine. Because these events were reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or to establish a causal relationship to Menactra® vaccine exposure. Transient System disorders - hypersensitivity reactions such as anaphylactic/anaphylactoid reactions, wheezing, difficulty breathing, upper airway swelling, urticaria, erythema, pruritus, vasodilation. Nervous system disorders Guillain-Barré syndrome, vasovagal syncope, facial palsy, transverse myelitis, acute disseminated encephalomyelitis, pancreatitis, Musculoskeletal and connective tissue disorders - Myalgia INTERACTIONS: Do not mix Menactra® vaccine with other vaccines in the same syringe. When Menactra® vaccine is administered concurrently with other injectable vaccines, the vaccines should be administered with different syringes and given at separate injection sites. Ref No. MY MPI Menactra® 02/2012/013

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