The immunologic responses following 3 doses of DTaP-HepB-IPV were generally similar to those following 3 doses of separately administered INFANRIX®, ENGERIX-B®, and oral poliovirus vaccine (*5*). Immunogenicity data from simultaneous administration of DTaP-HepB-IPV, with both *Haemophilus influenzae* type b (Hib) conjugate vaccine and pneumococcal conjugate vaccine (PCV), are unavailable (*4*).

Except for fever, the rates of most solicited local and systemic adverse events following DTaP-HepB-IPV were comparable to rates observed following separately administered U.S.-licensed vaccines. In comparative studies, administration of DTaP-HepB-IPV and Hib vaccine was associated with higher rates of fever relative to separately administered vaccines (*5,6*). In an ongoing study, infants who received the first dose of DTaP-HepB-IPV with Hib vaccine and PCV had higher rates of fever compared with infants who received separately administered vaccines (*4*).

ACIP Approval of DTaP-HepB-IPV for the Vaccine for Children Program

ACIP has approved the use of PEDIARIX™ for the Vaccine for Children program and recommends that, in addition to FDA-approved uses, 3 doses of PEDIARIX™ can be administered to an infant who is born to a woman who is hepatitis B surface antigen (HBsAg)-positive or whose HBsAg status is unknown. ACIP also approved a minimum interval of 4 weeks between the first and second doses when used in an accelerated vaccination schedule; the third dose should not be given before age 24 weeks.

Indications and Usage

Primary series

1. DTaP-HepB-IPV is approved for the primary series at ages 2, 4, and 6 months. The vaccine should not be administered to any infant aged <6 weeks or any person aged ≥7 years. The recommended interval between doses is 6–8 weeks (preferably 8 weeks) (*4*).
2. DTaP-HepB-IPV can be used to complete the primary series in infants and children who have received INFANRIX® (DTaP) and are scheduled to receive the other components of the combination. Data are limited on the safety and immunogenicity of interchanging currently used DTaP vaccines from different manufacturers (*7*). ACIP recommends that, whenever feasible, the same brand of DTaP should be used for the primary series but that vaccination should not be deferred because the type of DTaP previously administered is unavailable or unknown (*7*).
3. All infants should receive a single antigen HepB vaccine soon after birth and before hospital discharge; the first dose can be given by age 2 months if the infant's mother is HbsAg-negative (*1*). For optimal prevention of perinatal infection, infants born to women who are HBsAg-positive must receive their first dose of single antigen HepB vaccine and hepatitis B immune globulin (HBIG) within 12 hours of birth and ≥3 doses of HepB vaccine by 6 months of age. Women of unknown HBsAg status who give birth should be tested for HBsAg immediately and their infants administered single antigen HepB vaccine within 12 hours of birth; these infants also should receive HBIG if the woman is found to be HBsAg-positive. Except for doses administered at age <6 weeks of age, DTaP-HepB-IPV can be used in a HepB vaccine series for any infant. However, infants born to HBsAg-positive women should begin DTaP-HepB-IPV beginning by age 6–8 weeks after receiving single antigen vaccine at birth. Use of DTaP-HepB-IPV after single antigen HepB vaccine is administered at birth will result in a 4-dose HepB vaccine series (*1*); this is considered acceptable by ACIP (*3*).
4. DTaP-HepB-IPV and HepB vaccine from a different manufacturer are interchangeable for HepB vaccination (*3*). DTaP-HepB-IPV and IPV from a different manufacturer are interchangeable for poliovirus vaccination (*4*).
5. DTaP-HepB-IPV combination can be administered with Hib and PCV vaccines at separate injection sites (*7*).

Boosters

1. The DTaP-HepB-IPV combination is not approved for the fourth dose of IPV or the fourth and fifth dose of DTaP (*4*).

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4. PEDIARIX™ [Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Hepatitis B (Recombinant) and Inactivates Poliovirus Vaccine Combined] Prescribing information. SmithKline Beecham Biologicals, Rixensart, Belgium, December 2002.
5. Yeh SH, Ward JI, Partridge S, et al. Safety immunogenicity of a pentavalent diphtheria, tetanus, pertussis, hepatitis B and polio combination vaccine in infants. Pediatr Infect Dis J 2001;20:973–80.
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7. CDC. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP). MMWR 2002;51(No. RR-2).

Errata: Vol. 52, No. RR-1

In the *MMWR Recommendations and Reports*, "Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings," published on January 24, 2003, an error occurred on page 4 in the second sentence of the paragraph under Occupational Exposures. The sentence should read, "Occupational transmission of HBV infection among hospital-based workers has been linked to percutaneous and mucous membrane exposures, and HCV infection has been primarily associated with percutaneous exposure."

On page 12, in Box 6, the fourth item under Type of Exposure should read, "Household (e.g., cell or dormitory) contact — to person with chronic HBV infection."

On page 2, errors occurred in Table 1, and on page 20, errors occurred in Table 5. The correct tables follow.

TABLE 1. Estimated chronic infections with hepatitis viruses among inmates and releasees — United States, 1997

Chronic infection	Number and percent of jail and prison inmates with condition*	Number and percent among noninmate population with condition	Number among total U.S. population with condition	Number of releasees with condition and as percentage of U.S. population with condition†
Hepatitis B virus	34,000 (2%)§	1 million–1.25 million (0.5%)¶	1.036 million–1.29 million	155,000 (12%–15%)
Hepatitis C virus	255,000 (15%)**	2.7 million (1.3%)††	2.97 million	1.16 million (39%)

Source: Adapted from National Commission on Correctional Health Care. The health status of soon-to-be-released inmates: a report to Congress. Chicago, IL: National Commission on Correctional Health Care, 2002. Available at http://www.ncchc.org/pubs_stbr.html.

* Based on 1.7 million inmates in prisons and jails, 1997 (*15*).
† Based on estimated 7.75 million unduplicated released inmates (*2*); A. Beck, Ph.D. Bureau of Justice Statistics, personal communication, 2002.
§ (*31*,*83*,*84*,*85*,*86*,*88*,*89*,*90*,*92*,*94*).
¶ Data from CDC, National Center for Health Statistics, National Health and Nutrition Examination Survey (NHANES III), adjusted to include persons of Asian origin (*76*).
** (*88*,*121*,*122*); L. Wang, Ph.D., New York State Department of Health, personal communication, 2001; D. Lau, M.D., University of Texas Medical Branch—Galveston, personal communication, 2001.
†† Based on data from NHANES III (*107*).

TABLE 5. Postexposure prophylaxis for exposure to hepatitis B virus in correctional settings

Vaccination and antibody response status of exposed person*	Treatment when source is found to be HBsAg† positive	HBsAg negative	HBsAg unknown or not available for testing§
Unvaccinated	HBIG¶ x 1, and initiate HB vaccine series**	Initiate HB vaccine series	Initiate HB vaccine series
Previously vaccinated			
Known responder††	No treatment	No treatment	No treatment
Known nonresponder§§	HBIG x 2, or HBIG x 1 and initiate re-vaccination¶¶	No treatment	Treat as if source were HBsAg positive§
Antibody response unknown	Test exposed person for anti-HBs*** 1. If adequate, no treatment is necessary.†† 2. If inadequate, administer HBIG x 1 and vaccine booster.†††	No treatment	Treat as if source were HBsAg positive§

Source: Adapted from CDC. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. MMWR 2001;50 (No. RR-11):1–52.

* Persons who have previously been infected with HBV are immune to reinfection and do not require postexposure prophylaxis.
† Hepatitis B surface antigen.
§ Inmates should be considered persons at probable high risk.
¶ Hepatitis B immune globulin; dose is 0.06 mL/kg body weight intramuscularly.
** Hepatitis B vaccine.
†† A responder is a person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs ≥10 mIU/mL).
§§ A nonresponder is a person with inadequate response to vaccination (i.e., anti-HBs <10 mIU/mL).
¶¶ The option of administering one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, 2 doses of HBIG are preferred.
*** Antibody to HBsAg.
††† For persons with ongoing exposure, such as health-care workers, recheck anti-HBs level in 1 month.