

10

Mumps

Introduced in 1988 as part of MMR

NOTIFIABLE

Introduction

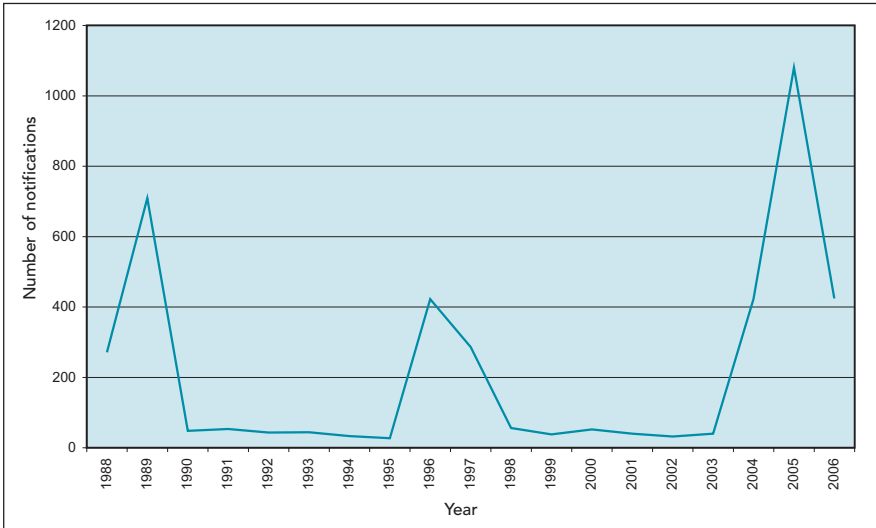
Mumps is an acute viral illness caused by a paramyxovirus. Humans are the only known host. It is characterised by swelling of one or more of the salivary glands, usually the parotid. The virus can be isolated from 2-7 days before to 9 days after onset of symptoms. Approximately 10 secondary infections will result from each index case in a fully susceptible population.

Epidemiology

Transmission is by airborne or droplet spread. The incubation period is approximately 17 days (range 14-25 days). Cases are infectious from about 6 days before to 10 days after onset of symptoms, although maximum infectivity is from 2 days before to 5 days after onset of symptoms. High-risk groups are those in a close-contact environment such as pre-school, school and third-level colleges, health-care workers, and international travellers. Recently in Ireland the highest incidence has been in 18-24 year olds.

A national mumps outbreak commenced in November 2004 (Figure 10.1). The outbreak predominantly affected those born before 1988, particularly those born between 1983 and 1986. MMR was first introduced in 1988.

Figure 10.1 Annual number of mumps notifications in Ireland, 1988-2006.
Source: HPSC



Effects of mumps

Up to 40% of mumps infections may be asymptomatic and up to 50% will have non-specific or primarily respiratory symptoms.

Prodromal symptoms are non-specific and include myalgia, low-grade fever, anorexia, and headache. Salivary gland inflammation, particularly of the parotid gland (unilateral or bilateral), is the most common manifestation and occurs in 50-70% of affected individuals.

Mumps virus affects the CNS in up to 50% of cases, but less than 10% are symptomatic. Typically, symptoms are mild, with meningism (headache, photophobia and neck stiffness) being the commonest. Other CNS manifestations include encephalitis, ataxia, transverse myelitis, and sensorineural deafness. Meningoencephalitis occurs more frequently in adults than children and in boys more than girls. It resolves without sequelae in 3-10 days. Parotitis may be absent in up to 50% of these cases.

Other complications include pancreatitis (4%), orchitis (approximately 25% of post-pubertal men, rarely causing sterility), oophritis and mastitis in post-pubertal females, and nephritis. Rarer complications include arthralgia, arthritis and cardiac abnormalities. Death is rare.

Mumps vaccine

Mumps vaccine is only available as MMR (Measles, Mumps and Rubella vaccine). The vaccine contains attenuated measles, mumps and rubella which are cultured separately and mixed before lyophilisation.

The lyophilised powder is reconstituted using the diluent supplied and shaken well to completely dissolve the pellet. The reconstituted vaccine is yellow in colour and should only be used if clear and free from particulate matter.

An up-to-date list of licensed vaccines is contained in Appendix 1, or can be accessed on the IMB website, www.imb.ie.

MMR does not contain thiomersal or any other preservatives. It must be kept refrigerated at 2-8°C, and protected from light. It should be used within 1 hour of reconstitution. Failure to adhere to these recommendations can result in loss of vaccine potency and diminished effectiveness.

Over 90% of individuals develop immunity to measles and rubella after 1 dose of vaccine. Two doses give protection in over 98% of people (see point 1, Indications). Between 61% and 91% are protected against mumps after 1 dose; and 98% are protected after 2 doses. Serological and epidemiological evidence indicates that vaccine-induced immunity is possibly lifelong.

Low rates of seroconversion occur in those under 12 months of age, because of maternal antibodies.

Deferral of MMR following blood or immunoglobulin transfusion (except anti-RhD immunoglobulin, see p. 90/112/145)

Deferral of MMR following blood or immunoglobulin transfusion
Blood and blood products may contain significant levels of virus-specific antibody, which could prevent vaccine virus replication. Where possible, MMR should be deferred for at least 3 months after receipt of low-dose immunoglobulin, 6 months after red-cell transfusion, and 11 months after high-dose immunoglobulin (as for Kawasaki Disease). Anti-RhD immunoglobulin can be administered simultaneously or at any time in relation to MMR (varicella on page 142). If the MMR vaccine is administered within these timeframes, a further dose should be given outside these times.

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Laboratory investigation to determine vaccine response is not routinely recommended.

Persons who are tuberculin-positive may have a negative tuberculin test for 3 months after measles infection or MMR vaccine.

Scientific evidence shows no association between the MMR vaccine and autism or inflammatory bowel disease.

Dose and route of administration

The dose is 0.5 ml by deep intramuscular injection. The deltoid is the recommended site of administration. The anterolateral thigh may also be used.

Alcohol swabs are best avoided as alcohol can inactivate the MMR vaccine. If alcohol is used to clean the skin it must be allowed to evaporate completely before the injection is given.

When other injectable vaccines are being given concurrently with MMR, different sites should be used.

MMR may be given at the same time as DTaP, IPV, MenC, Hib and Hep B in situations where the latter are overdue.

Indications

1. All children at 12-15 months of age, with a second dose at 4-5 years of age. For older children who have not received 2 doses, MMR vaccine should be given as soon as possible, and a second dose one month later. Allowing 3 months between doses is likely to maximise the response rate in children aged under 18 months. Where protection against mumps is urgently required the second dose can be given 1 month after the first. If children aged under 18 months are given the second dose less than 3 months after the first dose, they need a third dose to ensure full protection. This can be given at 4-5 years. MMR vaccine can be given to those who have a history of measles, mumps or rubella infection.
- 2 Children coming from low-income countries have probably received measles vaccine but may not have received rubella or mumps vaccine. Therefore, unless there is a reliable history of vaccine administration,

these children should be regarded as unimmunised, and given 2 doses of MMR one month apart.

3. Individuals born before 1978 are likely to have had mumps infection. MMR vaccine is not routinely recommended but may be offered to such individuals on request if they are considered at high risk of exposure.
4. Health-Care Workers (HCWs) in the following situations (see Chapter 18). Protection is important both for themselves and in the context of their ability to transmit mumps to vulnerable groups.
 - Those who do not have evidence either of mumps infection or of having received 2 doses of MMR vaccine should be given 2 doses of MMR, separated by at least 1 month.
 - If an outbreak occurs in an institution or an area served by an institution, HCWs without a history of mumps infection or of having received two doses of MMR should be given 2 doses of MMR.

Antibody response to the mumps component of the MMR vaccine **does not** develop quickly enough to provide effective prophylaxis after exposure to suspected mumps. However, the vaccine can provide protection against future infection. Therefore, contact with suspected mumps provides a good opportunity to offer MMR to previously unvaccinated individuals. If the individual is already incubating mumps, MMR vaccination will not exacerbate the symptoms. Human normal immunoglobulin is not routinely used as post-exposure protection from mumps.

Contraindications

1. Anaphylaxis following a previous dose of MMR or one of its constituents (e.g. Neomycin, Gelatin)
2. Significantly immunocompromised persons, such as those with untreated malignant disease and immunodeficiency states other than HIV infection, and those receiving immunosuppressive therapy, high-dose x-ray therapy and current high-dose systemic corticosteroids (see Chapter 2)
3. Pregnancy. Furthermore, pregnancy should be avoided for 1 month after MMR

There is no evidence to recommend or support the use of single vaccines against measles, mumps or rubella in place of the combination MMR vaccine.

The following are NOT contraindications to MMR vaccine

1. Allergy to egg, even anaphylaxis following egg. If there is a genuine concern regarding serious allergy, a paediatrician may be consulted and the vaccine given in hospital although this is not medically necessary. Currently-used measles and mumps vaccines do not contain significant amounts of egg cross-reacting proteins and recent data suggest that anaphylactic reactions to MMR are not associated with hypersensitivity to egg antigens but to other vaccine components (Gelatin or Neomycin)
2. Breast-feeding
3. HIV-positive patients who are not severely immunocompromised
4. Personal or family history of convulsions. Advice regarding the possibility and treatment of pyrexia should be given
5. Immunodeficiency in a family member or household contact
6. Uncertainty as to whether a person has had 2 previous MMR vaccines
7. Administration of anti-RhD immunoglobulin. As anti-RhD immunoglobulin does not interfere significantly with the antibody response to MMR (varicella on p. 145) vaccine, the two injections may be given simultaneously (in different syringes, at different sites), or at any time in relation to each other.

Precautions

1. Acute severe febrile illness, defer until recovery
2. Injection with another live vaccine within the previous 4 weeks
3. Recent administration of blood or blood products (see above)
4. Patients who developed thrombocytopenia within 6 weeks of their first dose of MMR should undergo serological testing to decide whether a second dose is necessary. The second dose is recommended if the patient is not fully immune to the 3 component viruses.

Adverse reactions

Soreness and erythema may occur at the injection site (3-8%). Fever (6%), rash (7%), headache, vomiting and salivary gland swelling may occur. A febrile convulsion occurs in 1 in 1,000 children.

'Mini-measles' may occur 6-10 days after immunisation and consists of mild pyrexia and an erythematous rash. 'Mini-mumps' with salivary gland swelling may rarely occur during the third week after immunisation. Very rarely, anaphylaxis, erythema multiforme, thrombocytopenia, and nerve deafness have been reported.

The rubella component may occasionally produce a rash, mild arthralgia, and lymph-node swelling 2-4 weeks post-vaccination, particularly in post-pubertal females (up to 25% of recipients). The incidence is lower than after natural disease.

There is no evidence of congenital rubella syndrome or increase in other teratogenic effects in women inadvertently given rubella vaccine before or during early pregnancy, but pregnancy remains a contraindication.

Adverse reactions are considerably less common (under 1%) after a second dose of MMR.

Bibliography

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