The Australian Standard Vaccination Schedule 2000–2002

The Australian Standard Vaccination Schedule shown here is that recommended by the National Health and Medical Research Council (NHMRC). In drawing up its recommendations the NHMRC has sought to reduce the number of injections given at each immunisation session through the use of new combination vaccines and to limit, as far as possible, the number of vaccine products that a practitioner would need to have available. For the immunisations at 2, 4, 6 and 12 months, two options for the use of combination vaccines which meet these criteria are recommended.

The Australian Standard Vaccination Schedule 2000–2002
For children born on or after 1 May 2000

New South Wales, Queensland, South Australia, Australian Capital Territory and Northern Territory follow Path 1. Victoria, Western Australia and Tasmania follow Path 2.

Immunisation Schedule

Age	*Vaccine*	
Birth	hepB[a]	
	Path 1[b]	**Path 2**[b]
2 months	DTPa-hepB and Hib (PRP-OMP) and OPV	DTPa[c] and Hib (PRP-OMP)-hepB and OPV
4 months	DTPa-hepB and Hib (PRP-OMP) and OPV	DTPa[c] and Hib (PRP-OMP)-hepB and OPV
6 months	DTPa-hepB and OPV	DTPa[c] and OPV
12 months	MMR and Hib (PRP-OMP)	MMR and Hib (PRP-OMP)-hepB
18 months	DTPa	
4 years	DTPa and MMR and OPV	
10–13 years	hepB[d]	
1 month later	hepB[d]	
5 months after 2nd dose	hepB[d]	
15–19 years	Td OPV	
Non-immune women who are post-partum or of child bearing age	MMR	
50 years	Td[e]	
50 years and over (Aboriginal and Torres Strait Islander people)	Pneumococcal vaccine (every 5 years) Influenza vaccine (every year)	
65 years and over	Pneumococcal vaccine (every 5 years) Influenza vaccine (every year)	

Notes

a. Hepatitis B vaccine should be given to all infants at birth and should not be delayed beyond 7 days after birth. Infants whose mothers are hepatitis B surface antigen positive (HBsAg+ve) should also be given hepatitis B immunoglobulin (HBIG) within 12 hours of birth.

b. When necessary the two paths may be interchanged with regard to their hepatitis B and Hib components. For example, when a child moves interstate, they may change from one path to the other.

c. Wherever possible the same brand of DTPa should be used at 2, 4 and 6 months.

d. Adolescent hepatitis B vaccination is not necessary for those children who have previously received three doses of hepatitis B vaccine.

e. Td should be given at 50 years of age unless a Td booster dose has been documented in the previous 10 years.

Vaccines used in the Schedule

Disease	*Vaccine*
Hepatitis B	hepB
Diphtheria, Tetanus, Pertussis	DTPa
Diphtheria, Tetanus, Pertussis, Hepatitis B	DTPa-hepB
Haemophilus Influenzae type B	Hib (PRP-OMP)
Haemophilus Influenzae type B, Hepatitis B	Hib (PRP-OMP)-hepB
Poliomyelitis	OPV
Measles, Mumps, Rubella	MMR
Diphtheria, Tetanus	Td
Pneumococcal disease	Pneumococcal vaccine
Influenza	Influenza vaccine

Transition from the old to the new schedule

All babies born on or after 1 May 2000 should commence the new Australian Standard Vaccination Schedule. Because of logistics, funding and vaccine interchangeability issues, all children born before this date should commence or continue with the previous schedule.

Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

Antidepressants

Editor, – I agree entirely with the sentiments of Dr O'Dempsey (Aust Prescr 2000;23:5) that newer drugs are rarely, if ever, measured against the performance of 'active' placebos. I think very few would pass muster if they were.

In the case of any antidepressant, I would personally be very surprised if any performed better than pheniramine *p*-aminosalicylate. I would be amazed if any hormone replacement therapy performed better than spironolactone 100 mg second daily. I would be astounded if any antipsoriasis treatment compared favourably against miconazole and zinc nappy ointment. I would also personally be stupefied if any ear drop could compare with half strength Burow's solution.

Peter Rout
General Practitioner
Darlington, NSW

Digoxin interactions

Editor, – During December 1999, I witnessed a case that motivated me to read the article 'Digoxin in the 21st century' (Aust Prescr 1999;22:136–7) with accentuated attention. The case was a 56-year-old woman who had suffered from schizophrenia six years ago and had since remained mentally balanced. She has been hypertensive for the past two years and was placed on medications. She had minor congestive heart failure last October (attributed to non-compliance with antihypertensive medications) and was admitted to a rural hospital. After rapid digitalisation she was placed on digoxin (0.125 mg/day) and hydralazine, but when the doctor started noting some neurological imbalance, chlorpromazine was added. On discharge, chlorpromazine and hydralazine were discontinued while digoxin was maintained. Sinepress (dihydroergotoxine 0.6 mg, reserpine 0.1 mg, hydrochlorothiazide 10 mg) was added. However, around the middle of December, she reverted back to a schizophrenic state, for which she is still being treated.

Does Dr Semsarian think that this bout of schizophrenia may have been precipitated by the adverse effects of digoxin ('digitalis delirium', confusion and hallucination) or to digoxin's common drug interactions, say, with the components of the combination antihypertensive drug?

Hypokalaemia induced by potassium-depleting diuretics is known to be the cause of adverse drug interactions between digoxin and such diuretics. The first self-test question