# Zoster Vaccine, Severe Skin Diseases Don't Mix

BY BRUCE JANCIN

SAN FRANCISCO — Immunization with the live attenuated herpes zoster vaccine (Zostavax) probably isn't worth the potential risks in patients with psoriasis or other chronic inflammatory skin diseases, Dr. Alice Gottlieb said.

"My personal feeling is that I would not use this vaccine to immunize patients with psoriasis, atopic dermatitis, or some other severe skin diseases," said Dr. Gottlieb at the annual meeting of the American Academy of Dermatology.

There are no data to show that the zoster vaccine is safe in such patients. And there is cause for concern, just as there would be in other immunocompromised individuals such as those with cancer or AIDS. Indeed, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) specifically recommends that the vaccine not be administered to those latter groups, she noted.

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DR. GOTTLIEB

There are no guidelines regarding the immunization of household contacts of patients with chronic inflammatory skin diseases. Here again, Dr. Gottlieb, who is chair of the department of dermatology and dermatologist-in-chief at Tufts Medical Center, Boston, urged caution.

Like other immunocompromised patients, individuals with chronic inflammatory skin diseases are at risk of developing Kaposi's varicelliform eruptions from household contacts who have received the zoster vaccine and are shedding live virus, she said.

"I happen to have a mother with psoriatic arthritis who's on etanercept. I waited until she was away visiting my twin sister elsewhere before I had my over-60 husband immunized with the zoster vaccine because I didn't want him to be shedding virus all over her," Dr. Gottlieb explained.

The ACIP guidelines state that the zoster vaccine should not be given to patients who are on recombinant human immune mediators, specifically naming the tumor necrosis factor–alpha blockers.

The guidelines also state that patients on prednisone at less than 20 mg/day or methotrexate at less than 0.4 mg/kg per week for psoriasis, rheumatoid arthritis, sarcoidosis, and other conditions are not considered sufficiently immunosuppressed to create vaccine safety concerns.

But these recommendations are based on expert opinion, not data, and Dr. Gottlieb's own opinion is that the use of the zoster vaccine in patients who are on low doses of these immunosuppressive drugs for inflammatory skin diseases ought to be formally studied before concluding that it is safe.

Other unresolved issues regarding the herpes zoster vaccine include its cost-effectiveness, particularly if use of the vaccine were to be expanded to those aged 50-59 years, she said.

Patients in that age group are at increased risk for herpes zoster and postherpetic neuralgia, but are not currently eligible for the vaccine, as all of the nearly 39,000 participants in the pivotal clinical trial were older than age 60 years (N. Engl. J. Med. 2005;352:2271-84).

Another open issue is whether a booster shot will be necessary; the vaccine hasn't been around long enough yet to know, Dr. Gottlieb added.

She also commented on another vaccine for the prevention of dermatologic disease, one she endorses utterly without reservation: the three-shot intramuscular Gardasil series for prevention of diseases related to infection with human papillomavirus types 6, 11, 16, and 18.

"When I was a resident in internal medicine, we saw lots of women dying from cervical cancer. This vaccine will prevent that from happening," she said.

Dr. Gottlieb reported that she had no financial conflicts of interest regarding her presentation. ■