Adult Immunization Recommendations Updated

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Updated adult immunization recommendations for the October 2007 through September 2008 season include the addition of zoster vaccine and the differentiation of HIV patients based on their CD4+ T-lymphocyte counts.

Developed by the Advisory Committee on Immunization Practices, the schedule can be viewed at www.cdc.gov/vaccines/ recs/schedules/adult-schedule.htm or the Oct. 19 issue of the Morbidity and Mortality Weekly Report (2007;56:RR-4).

Zoster vaccine has been added as a new recommendation covering persons aged 60 years or more, regardless of prior history of herpes zoster. Contraindications for this vaccine have been specified for pregnancy, immunocompromising conditions, and HIV patients with CD4+ T-lymphocyte counts under 200 cells/mcL. The vaccine is neither recommended nor con-traindicated for HIV patients with higher CD4+ T-lymphocyte counts.

The recommendation for varicella vaccine has been extended to include all age groups, including adults, in whom there is no evidence of varicella immunity. This recommendation includes persons infected with HIV if their CD4+ T-lymphocyte counts are at least 200 cells/mcL; the vaccine is contraindicated in HIV-infected patients with lower counts, as well as in pregnant women and in patients with other immunocompromising conditions.

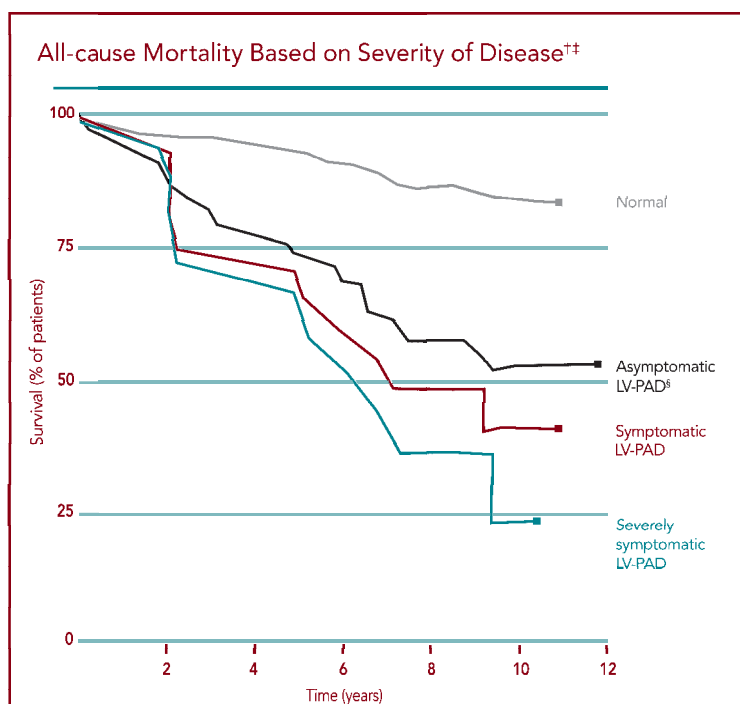Evidence of varicella immunity is defined as fulfilling any of these criteria:
▶ Documentation of two doses of varicella vaccine at least 4 weeks apart.
▶ Birth in the United States before 1980—not including health care personnel, immunocompromised persons, or pregnant women.
▶ History of varicella infection verified by a health care provider.
▶ History of herpes zoster infection verified by a health care provider.
▶ Laboratory evidence of immunity or disease confirmation.

The recommendations also specify that health care personnel can receive either a trivalent inactivated influenza virus vaccine or a live, attenuated virus vaccine. ◼

GBS Is Precaution For Menactra Administration

ATLANTA — A history of Guillain-Barré syndrome is a precaution for administration of the tetravalent meningococcal conjugate vaccine, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices voted at its fall meeting.

A precaution is a condition that might increase the risk for a serious adverse reaction or compromise the vaccine's ability to produce immunity, according to the CDC. However, the risk is less than that expected for a contraindication. Although vaccinations normally should be deferred in the case of a precaution, in some instances, the benefit of protection might outweigh the potential risk.

Guillain-Barré syndrome is a subacute-onset neuropathy involving bilateral, symmetric, flaccid paralysis. The condition has an autoimmune etiology, with vaccines accounting for some reported cases.

The most notable episode involved the 1976 "swine flu" vaccine, in which the attributable risk was 5-12 cases per million (Am. J. Epidemiol. 1979;110:105-23).

As of October 2007, VAERS has received 24 reports of Guillain-Barré syndrome following use of the tetravalent meningococcal conjugate vaccine (MCV4), marketed as Menactra by Sanofi Pasteur. There were 20 cases in 15- to 19-year-olds, 2 cases in 11- to 14-year-olds, and 2 cases in persons at least 19 years of age. Among the 22 adolescents, the onset of symptoms occurred 2-33 days after vaccination, with a cluster of 13 cases occurring at 9-16 days.

MCV4 thus is predicted to result in five excess cases of Guillain-Barré syndrome per million 11-year-olds vaccinated. The vaccine would prevent an estimated 359 cases of meningococcal disease and 35 associated deaths in the same group.

Dr. Thomas Clark, of the Meningitis and Vaccine Preventable Diseases Branch of the National Center for Immunizations and Respiratory Diseases, noted that this risk is comparable with that of influenza vaccine.
—**Melinda Tanzola**

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8 million Americans suffer from PAD[2]

It is estimated that between 12% to 20% of the US population 65 or older have PAD.[2]

PAD patients face an increased risk of mortality

All-cause Mortality Based on Severity of Disease[†‡]

Patients with PAD were **5.9 times more likely to die** of CV disease than patients without PAD.[3]

[†]Adapted from Criqui et al. *N Engl J Med.* 1992;326:381-386.
[‡]Kaplan-Meier survival curves based on mortality from all causes.
[§]LV-PAD=large-vessel PAD.

PAD and the Health Care Provider

ACC/AHA PAD guidelines point out that primary care providers are in the best position to detect PAD.[4]

It is estimated that

only 25% of patients diagnosed with PAD are undergoing treatment[2]

The ACC/AHA PAD Guidelines Class 1 Recommendations for PAD patients include both:

—Symptom relief management for claudication

—CV risk reduction to reduce future events such as MI, stroke, and vascular death

Find out more about PAD

The Peripheral Arterial Disease (P.A.D.) Coalition, www.padcoalition.org, is an alliance of more than 50 leading health organizations, vascular health professional societies, and government agencies united around a common purpose—to raise public and health professional awareness about lower extremity PAD.

The P.A.D. Coalition offers tools and information to improve the prevention, early detection, treatment, and rehabilitation of people with, or at risk for, PAD.

Bristol-Myers Squibb/Sanofi Pharmaceuticals Partnership is a proud sponsor of the P.A.D. Coalition.

References: **1.** Steg PG, Bhatt DL, Wilson PWF, et al, for the REACH Registry Investigators. One-year cardiovascular event rates in outpatients with atherothrombosis. *JAMA.* 2007;297:1197-1206. **2.** American Heart Association. *Heart Disease and Stroke Statistics—2007 Update.* Dallas, Tex: American Heart Association; 2007. **3.** Criqui MH, Langer RD, Fronek A, et al. Mortality over a period of 10 years in patients with peripheral arterial disease. *N Engl J Med.* 1992;326:381-386. **4.** Hirsch AT, Haskal ZJ, Hertzer NR, et al. ACC/AHA 2005 guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic). 2006. http://www.acc.org. Accessed May 4, 2006.

CV=cardiovascular.   CVD=cerebrovascular disease.
PAD=peripheral arterial disease.   ACC/AHA=American College of Cardiology/American Heart Association.
CAD=coronary artery disease.