Therefore, contact with the following should be avoided if a vaccine-related cutaneous rash develops within 4–6 weeks of the first or second dose:

- varicella-susceptible pregnant women;
- individuals at high risk of severe varicella, including those with immunodeficiency or those receiving immunosuppressive therapy;

Healthcare workers who develop a generalised papular or vesicular rash on vaccination should avoid contact with patients until the lesions have crusted. Those who develop a localised rash after vaccination should cover the lesions and be allowed to continue working unless in contact with patients at high risk of severe varicella.

National shingles immunisation programme

The aim of the national shingles immunisation programme is to lower the incidence and severity of shingles in older people using the high potency, live varicella-zoster vaccine, *Zostavax*®. It is recommended that vaccination is routinely offered to people aged 70 years. A catch-up programme has also been rolled out (since 2013) in those aged 70-79 years, as this age group is likely to have the greatest benefit from vaccination.

In the 2016–2017 immunisation programme, varicella-zoster vaccine is recommended in adults who were 70 **or** 78 years of age on 1st September 2016. Patients who were eligible for vaccination in the first 3 years of the programme but have not been vaccinated against *herpes zoster* remain eligible until their 80th birthday; this includes patients who were aged 71–73 or 79 on 1st September 2016. Patients who have reached 80 years are no longer eligible for vaccination. A single dose of *Zostavax*® is likely to give protection for at least 7 years, but the need for, or timing of, a booster dose has not been established. Although *Zostavax*® is not recommended for the treatment of shingles or post-herpetic neuralgia, it can be given to those with a previous history of shingles; ideally the vaccine should be delayed until systemic antiviral therapy has been completed.

Varicella-zoster immunoglobulin p. 1360 is used to protect susceptible individuals at increased risk of severe varicella infection (*see* Immunoglobulins p. 1354).

Useful Resources

Advice reflects that in the handbook Immunisation against Infectious Disease (2013), which in turn reflects the guidance of the Joint Committee on Vaccination and Immunisation (JCVI). The advice also incorporates changes announced by the Chief Medical Officer and Health Department Updates. Chapters from the handbook (including updates since 2013) are available at:
www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Yellow fever vaccine

23-Jan-2020

MHRA/CHM advice: stronger precautions in people with weakened immunity and in those aged 60 years or older

The MHRA and CHM have released important safety information regarding the use of the live yellow fever vaccine in those with weakened immunity, and in those aged 60 years or older. For further information, see *Important safety information* for yellow fever vaccine, live p. 1397.

Overview

Yellow fever vaccine, live is an attenuated preparation of yellow fever virus grown in chick eggs. Yellow fever vaccine, live is recommended for:

- laboratory workers handling infected material;
- individuals aged 9 months or older who are travelling to, or living in areas or countries with a risk of yellow fever transmission;
- individuals aged 9 months or older who are travelling to, or living in countries that require an International Certificate of Vaccination or Prophylaxis (ICVP) for entry (information about countries at risk of yellow fever is available from the National Travel Health Network and Centre).

Children aged under 9 months are at higher risk of vaccine-associated encephalitis, with the risk being inversely proportional to age. Children aged under 6 months should **not** be vaccinated. Children aged 6–9 months should only be vaccinated following a detailed risk assessment, and vaccination is generally only recommended if the risk of yellow fever transmission is high (such as during epidemics/outbreaks). If travel is unavoidable, seek expert advice on whether to vaccinate.

Yellow fever vaccine, live should be avoided in individuals with primary or acquired immunodeficiency due to a congenital condition or disease process, and in individuals who are immunosuppressed as a result of treatment.

If the yellow fever risk is unavoidable in HIV-infected individuals, consult the British HIV Association (bhiva.org/vaccination-guidelines) or other specialist advice.

For additional guidance on the suitability of immunisation against yellow fever, standardised checklists are available from: National Travel Health Network and Centre (see *Useful resources*) or Health Protection Scotland (www.Travax.nhs.uk).

A single-dose of yellow fever vaccine, live confers life-long immunity against yellow fever disease. Immunisation should be performed at least 10 days before travelling to an endemic area to allow protective immunity to develop and for the ICVP (if required) to become valid.

Reinforcing immunisation is not needed, except for a small subset of individuals at continued risk who may not have developed long-term protection from their initial yellow fever vaccine, live vaccination–seek expert advice.

All suspected cases of yellow fever must be notified to the local health protection unit. Where there is a community level outbreak, specialist advice should be sought from Public Health England (tel. 020 8200 4400) or, in Scotland, Health Protection Scotland (tel. 0140 300 1191).

Useful Resources

Recommendations reflect Chapter 35, Yellow fever, in *Immunisation against infectious disease*- 'The Green Book'. Public Health England, January 2020.
www.gov.uk/government/publications/yellow-fever-the-green-book-chapter-35

National Travel Health Network and Centre
travelhealthpro.org.uk

Vaccines for travel

Immunisation for travel

See advice on Malaria, treatment p. 649.

No special immunisation is required for travellers to the United States, Europe, Australia, or New Zealand, although all travellers should have immunity to tetanus and poliomyelitis (and childhood immunisations should be up to date); Tick-borne encephalitis vaccine is recommended for immunisation of those working in, or visiting, high-risk areas. Certain special precautions are required in non-European areas surrounding the Mediterranean, in Africa, the Middle East, Asia, and South America.

Travellers to areas that have a high incidence of **poliomyelitis** or **tuberculosis** should be immunised with the appropriate vaccine; in the case of poliomyelitis previously immunised travellers may be given a booster dose