

Letters

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Varicella vaccination

Editor, – Before the universal varicella vaccination program, 95% of adults in the USA experienced natural chickenpox (usually as school-aged children). Most of these cases were benign and resulted in long-term immunity. This high percentage of individuals with long-term immunity has been compromised by mass varicella vaccination of children, which provides at best 70–90% immunity that is temporary and of unknown duration.^{1,2} This shifts chickenpox to a more vulnerable adult population in which chickenpox carries 20 times more risk of death and 15 times more risk of hospitalisation compared to children. This is in addition to the adverse effects of the chickenpox and shingles vaccines³, as well as the potential for increased risk of shingles for an estimated 30–50 years among adults.

As early as 1965 Dr Hope-Simpson suggested, 'The peculiar age distribution of zoster may in part reflect the frequency with which the different age groups encounter cases of chickenpox...'.⁴ A recent study found a 90% overall increase in adult shingles, from 2.77/1000 to 5.25/1000, during a period of increasing varicella vaccine coverage, 1998–2003.⁵ If the outcomes in this and other UK studies are due to an immunologically-mediated link (that is, low varicella incidence produces an increase in the incidence of herpes zoster), then the approximate 50% reduction in risk of herpes zoster achieved in a large trial of a zoster virus vaccine, at best reduces shingles incidence back to the precensure rate.

The universal varicella vaccination program currently requires a booster vaccine (recommended in children 4–6 years old) and a shingles vaccine (recommended in adults 60 years and older). However, these are less effective than the natural immunity that existed in communities prior to licensure of the varicella vaccine. Routine vaccination against chickenpox has produced continual cycles of treatment and disease.

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References

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Influenza vaccination

Editor, – I have an unanswered question after reading the article by Paul Dugdale (*Aust Prescr* 2007;30:35–7).

I have tended to discourage vaccinating young healthy adults with influenza vaccine as I was under the impression that an occasional bout of influenza in their younger years would prime the immune system and produce much better immune responses for future attacks that would keep them in good stead in their later years.

Is there any evidence for this? Is it a reasonable approach?

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General practitioner
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Dr Paul Dugdale, author of the article, comments:

There is a health benefit of infection with one subtype of influenza because, like vaccination with that subtype, it will produce immunity to that subtype and can produce partial immunity to other subtypes. However, compared to vaccination, any possible increased efficacy of wild infection in preventing future infection would be more than offset by the health cost of actually having the bout of influenza. Therefore choosing not to be vaccinated on the grounds of possible net future benefit is not reasonable.

It may of course be quite reasonable for a healthy adult to decline vaccination on the grounds that it is not worth their while to reduce their chance of getting wild influenza. A discussion of their particular life circumstances will assist such a decision.