To the Editor,

The timely and updated ECCO consensus guidance on opportunistic infections in the context of IBD will be widely welcomed.1 With reference to Varicella zoster virus (VZV) infection, ECCO still recommends using patient reported exposure history as an indicator of immunity and VZV IgG testing and immunization in those without a clear exposure or vaccination history.

The significantly higher risk of VZV infection in IBD patients, recognized from clinical trial data, bolstered by recent "real world" data and reports of severe, disseminated and occasionally fatal infection provide compelling reasons for a considered approach with a VZV history, raising debate on the appropriateness of patient-reported history alone as a measure of seroprotection.2

There have been a number of case reports of primary infection and a fatality among patients reporting primary infection but VZV IgG negative on testing.3 Kopylov and colleagues recently reported their experience in 121 IBD patients (87% on immunomodulators with Anti-TNF exposure in 71%) and noted that of 104 patients who recalled VZV exposure, 7 patients had negative or indeterminate VZV IgG.4 We recently reported our experience of accuracy of recall of VZV infection with corroborative serology.5 In a retrospective review of 220 IBD patients, data for VZV exposure and viral titres were available in 71 patients. Two-thirds were uncertain of prior VZV exposure. Although the overall prevalence of VZV IgG seropositivity was 87%, 10% were seronegative with a definite exposure history. These patients were on combined thiopurine and Anti-TNF immunosuppression.5 A total of 14% patients on immunomodulators were IgG seronegative and 40% of these were on bi-modal immunosuppressive therapy. Emerging evidence suggests that a significant percentage of patients may be seronegative despite a positive VZV exposure history.5

Such data assumes greater importance in an era where bolder definitions of disease control have translated into earlier and often combination immunomodulatory therapy with the potential for opportunistic infections, many of which are vaccine preventable. Vaccination of IBD patients meanwhile is a science in evolution raising as many questions as it seems to answer. Although recent data have shown that immunosuppressive medications are independently associated with VZV risk, it is still unclear if immunity conferred by prior vaccination is lost or attenuated by pharmacological immunosuppression.2

Although insufficient to influence consensus guidelines, such data provide compelling reasons for clinicians to pause to consider the consequences for a VZV seronegative patient on meaningful immunosuppression exposed to varicella infection. A strategy combining varicella exposure history with serology may identify history-positive yet seronegative individuals who merit vaccination, but arguably also identify history-negative yet seropositive individuals, resulting in a lower rate of unnecessary vaccination. There is an urgent need for more data, which could influence guideline development in this area.

Conflict of interest statement

Both authors have made an equal contribution to drafting the article, its revision and final approval of the submitted version. It has never been submitted for consideration of publication to any journal previously. The authors declare no conflict of interest.

References


Jimmy K. Limdi
Consultant Gastroenterologist and Clinical Lead - Inflammatory Bowel Diseases, The Pennine Acute Hospitals NHS Trust, Manchester, United Kingdom
Corresponding author at: 2.41 Fairfield House, Jericho Road, Bury, Manchester, BL9 7TD, UK. Tel.: +44 161 778 2642; fax: +44 161 778 2659.
E-mail address: jimmy.limdi@pat.nhs.uk.

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Divya Aggarwal
Inflammatory Bowl Diseases Section, The Pennine Acute Hospitals NHS Trust, Manchester, United Kingdom
E-mail address: divya.medic@gmail.com.