might render elderly travelers from industrialized countries fully susceptible to HAV infection. Conceptually this concern is suggested by experience with polio virus. A 65-year-old British male was afflicted by polio virus type 1 wild infection while on holidays in Morocco. In Morocco itself, yet another 62-year-old previously healthy man during a holiday in a beach resort acquired poliomyelitis. An extension of the recommendation of Laurichesse et al., to include HAV vaccination of elderly travelers might be essential to ensure their protection from HAV infection and to avoid the importation of HAV to industrialized countries.

HAV vaccination might also be indicated among expatriates in endemic countries even if they are housed in modern residential apartments with a potable water supply and modern sanitary conditions. They might not acquire HAV infection while living in such an environment, but any accidental or intentional visit to locations outside such dwellings (e.g., to holiday resorts) would likely be associated with acquiring HAV infection. HAV vaccine would be indicated for children and adolescents of expatriates living in modern residential apartments when they venture outside the modern confines or otherwise visit an HAV endemic foci.

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References


The Authors Reply

To the Editor:

Following the publication of symptomatic cases of hepatitis A virus (HAV) infection affecting young scouts during a stay in a remote village in Ivory Coast, West Africa, the question raised by S.C. Arya is whether or not it would be wise to exclude elderly persons from HAV vaccination when they travel from low to high endemic areas. Our report did not suggest such a recommendation but pointed out the need for immunizing young travelers from low to high endemic areas.

Currently, the decreasing HAV sero-prevalence rate in industrialized countries and the high incidence of hepatitis A among travelers consistently support the implementation of active immunization using a formalin inactivated hepatitis A vaccine with a simplified schedule (two doses 6 to 12 months apart) for young individuals who are likely to be susceptible to HAV infection. This vaccine policy does not exclude elderly people from active protection against hepatitis A. However, since most adults over 40 years of age and elderly people have developed hepatitis A and have naturally acquired antibodies, it would be cost-effective to perform a pre-vaccination serologic screening for total HAV antibodies. A positive test suggests natural immunity and effective protection against hepatitis A, and will save vaccine doses.

In France, such a prevaccination screening is recommended for travelers over 40 years of age. A booster dose of combined polio and tetanus vaccine is recommended for travelers who failed to receive a dose of vaccine for more than 10 years using, when available, the inactivated polio vaccine combined with tetanus toxoid to prevent imported cases of poliomyelitis such as those reported. In addition, elderly persons who contribute to an increasing proportion of West European travelers from low to high endemic areas are more likely to develop a symptomatic or even severe hepatitis A than youngsters. They have to be offered appropriate medical management including hygienic counseling and information on HAV transmission and infection.

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References