Frequently asked questions

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Prescribing and adverse events reporting information can be found on page 6.
1. Can Zostavax® be given to asplenic patients?

Asplenia is not listed in the Summary of Product Characteristics (SPC) as a specific contraindication to receiving the vaccine.¹

What the Public Health England (PHE) Q&A says:

Eligible patients who have an absent or dysfunctional spleen should be offered Zostavax®, unless otherwise contraindicated as they have a significant ability to benefit from the vaccine.

Whilst there is no evidence relating specifically to the use of Zostavax® in splenectomy patients, asplenia or a dysfunctional spleen is not considered a contraindication to receiving the vaccine.

Live and inactivated vaccines are safely administered to children and adults with an absent or dysfunctional spleen routinely in primary care to offer protection against a range of vaccine preventable diseases.

However, whilst asplenia itself is not a contraindication to receiving Zostavax®, it is important for healthcare professionals to be aware of the underlying cause that has resulted in the absent or dysfunctional spleen, as this may be a contraindication to receiving the vaccine. For example, leukaemic infiltration is a potential reason for splenectomy, and so the patient may have an acute leukaemia which is one of the specific contraindications to use of Zostavax®.²

2. Can Zostavax® be given concomitantly with flu vaccine?

Zostavax® can be given at the same time as inactivated influenza vaccine as separate injections and at different body sites.¹

3. Can Zostavax® be given concomitantly with pneumococcal polysaccharide vaccine (PPV)?

The Zostavax® licence (SPC) states that it should not be given at the same time as PPV vaccination.¹
4. Is a booster dose required or is a single dose enough?

In the Long-term Persistence Substudy 6,867 subjects previously vaccinated with Zostavax® in the Shingles Prevention Study (SPS), were evaluated 10 years post-vaccination for duration of protection. The mean age at enrolment was now 74.5 years. The vaccine efficacy during follow-up was 21% for incidence of shingles and 35% for incidence of post-herpetic neuralgia.¹

The need for a second dose is currently unknown.¹

5. What is the required interval post-vaccination before any immunosuppressive therapy can be started?

Immunosuppressive therapy is a contraindication to Zostavax® (no guidance on intervals is given in the SPC).¹

What the PHE Q&A says:

The risk and severity of shingles is considerably higher amongst immunosuppressed individuals and therefore individuals anticipating immunosuppressive therapy should be assessed before starting treatment in relation to their vaccination status.

Eligible individuals who have not received zoster vaccine should receive a single dose of vaccine at the earliest opportunity at least 14 days before starting immunosuppressive therapy, although leaving one month would be preferable if a delay is possible.

6. Is Zostavax® vaccination beneficial for those patients with recurrent cases of shingles?

A history of shingles is not listed in the SPC as a contraindication to vaccination with Zostavax®. The SPC provides no guidance on a recommended interval between an episode of shingles and receipt of the vaccine. Zostavax® is not indicated for treatment of shingles or PHN.¹

What the PHE Q&A says:

What if an individual who is eligible for the national programme, presents with a previous history of shingles infection; should they still be offered the vaccine?
Yes, eligible individuals aged 70, 78 and 79 years of age should continue to be offered Zostavax® as part of the national programme, despite presenting with a previous history of shingles infection.\(^2\)

**What the Green Book says:**

Department of Health also advise that the vaccine is well tolerated and is also immunogenic in individuals who have had a history of shingles prior to vaccination. Individuals who have shingles or PHN should wait until symptoms have ceased before being considered for shingles immunisation.

The natural boosting that occurs following an episode of shingles, however, makes the benefit of offering zoster vaccine immediately following recovery limited. In immunocompetent individuals who develop shingles, vaccination should be delayed for one year. Patients who have two or more episodes of shingles in one year should have immunological investigation prior to vaccination. Clinicians may wish to discuss such cases with local specialist teams.\(^3\)

**7. Should patients avoid contact post-vaccination with anyone that is immunosuppressed or chickenpox/shingles naïve (e.g. grandchildren) and if so, for how long?**

Transmission of the vaccine virus has not been reported in clinical trials with Zostavax®. However, post-marketing experience with varicella vaccines suggests that transmission of vaccine virus may occur rarely between vaccinees who develop a varicella-like rash and susceptible contacts (for example, VZV-susceptible infant grandchildren).

Transmission of vaccine virus from herpes zoster vaccine recipients who do not develop a varicella-like rash has also been reported. This is a theoretical risk for vaccination with Zostavax®. The risk of transmitting the attenuated vaccine virus from a vaccinee to a susceptible contact should be weighed against the risk of developing natural zoster and potentially transmitting wild-type VZV to a susceptible contact.\(^1\)
8. How long should be left before Zostavax® vaccination following a case of shingles?

What the Green Book says:

Individuals who have shingles or post-herpetic neuralgia should wait until symptoms have ceased before being considered for Zostavax®. The natural boosting that occurs following an episode of shingles, however, makes the benefit of offering Zostavax® immediately following recovery limited. In immunocompetent individuals who develop shingles, vaccination should be delayed for one year.\(^3\)

Zostavax should not be administered to patients currently receiving oral or intravenous antiviral agents (such as aciclovir) or is within 48 hours after cessation of treatment due to the potential to lower effectiveness of the vaccine as the therapy may reduce the response to the vaccine.\(^2\) The use of topical aciclovir is not a contraindication to Zostavax\(^®\).\(^1,3\)

9. Can a patient on long-term steroids have Zostavax®?

Zostavax® is contraindicated in individuals receiving immunosuppressive therapy, including high-dose corticosteroids.\(^1\)

What the Green Book says:

Therapy with a single, low-dose, non-biological oral immune modulating drug, either alone or with low dose steroids, for treatment of rheumatoid arthritis, psoriasis, polymyositis, sarcoidosis, inflammatory bowel disease, and other conditions, are not necessarily sufficiently immunosuppressive to contraindicate administration of zoster vaccine. In these individuals, the degree of immunosuppression should be assessed on a case by case basis. Specialists with responsibility for patients in the vaccine eligible age cohorts should include a statement of their opinion on the patient’s suitability for Zostavax® in their correspondence with primary care. If clinicians administering the vaccine have concerns about the nature of therapies (including biologics) or degree of immunosuppression, they should contact the relevant specialists.\(^3\)
10. How are the cohorts chosen?

What NHS England says:

The roll out of this programme will be considered by NHS England, Public Health England and the Department of Health and will be phased in over a period of time due to both vaccine supply and ensuring a manageable implementation process. 

References: