Immunizations & Immunosuppression Guidelines

Presented by the IBD Committee and NASPGHAN

GUIDELINES

- The best time to vaccinate is when someone is newly diagnosed with inflammatory bowel disease (IBD), before any immunosuppressive therapy has begun.
- Immunosuppression is unpredictable and may blunt vaccine response.
- All inactivated vaccines can be administered safely to persons with IBD whether the vaccine is a killed whole-organism or a recombinant, subunit, toxoid, polysaccharide, or polysaccharide protein-conjugate vaccine. The usual doses and schedules of inactivated vaccines can be found at www.cdc.gov/vaccines/recs/schedules

SPECIAL CONSIDERATIONS

- Existing immunity (titers) to Hep B, MMR and Varicella may need to be checked:
  - before vaccination
  - before starting immunosuppressive therapy
- Varicella risk needs special attention before immunosuppression.
- Interval between initiation of the immunosuppressive therapy and pneumococcal vaccine should at least be 2 weeks.
- A booster for meningococcal vaccine may be given every 5 years in patients who continue to be immunosuppressed.
- Significant protein–calorie malnutrition is a risk factor for poor response to immunizations

<u>NO live vaccines should be given once immunosuppressive therapy has been initiated</u>

<u>Live Vaccines</u>

Rotavirus

Measles–Mumps–Rubella

Varicella/ Zoster

Intranasal Influenza

Typhoid

Yellow fever

<u>Time interval to start immunosuppression after live vaccine</u>:

- ➢ At least 1 month

<u>Time interval to give live vaccine after medication</u>:

Corticosteroids
(>20 mg/day or 2mg/kg or more per day and 2 weeks)

- ➢ At least 1 month

Azathioprine/6MP
Cyclosporine
Tacrolimus
Methotrexate

- ➢ At least 3 months

Anti-TNF or other biologics

- ➢ At least 3 months

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