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Safe Vaccination Usually Possible in Persons With Suspected Vaccine Allergies

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used in clinical practice. I think, on a selective basis, physicians have the discretion to say, 'For this patient, I don't know what to do, and adding another test might help me'—and that is always the case in medicine."

The task force recommendations also run slightly counter to recommendations emanating from organizations such as the American Heart Association (AHA) and American College of Cardiology (ACC). Expert panels are working with these two groups to prepare updated guidelines, expected to be released next year, that address risk assessment as well as cholesterol and blood pressure findings. "One area of departure . . . is that the AHA/ACC may, in fact, offer

a recommendation with the level of evidence cited, whereas the [task force], in general, is less inclined to recommend anything if there is not a strong evidence base," said Sidney C. Smith Jr, MD, professor of medicine at the University of North Carolina School of Medicine in Chapel Hill, who is working with the expert panels.

Michael S. Lauer, MD, director of the National Heart, Lung, and Blood Institute's Divisions of Prevention and Population Sciences and of Cardiovascular Diseases, said the task force has a well-deserved reputation for taking a rigorous look at the evidence. "Personally, I agree with that," said Lauer. "One of the major problems we have with diagnos-

tic testing is that with few exceptions, there is very little evidence that use [of such tests] results in improved health."

Calonge said he gets frustrated with advocates of nontraditional markers for assessing coronary heart disease risk because the tried-and-true treatments that will reduce risk continue to be underused. "There are thousands of life-years being left on the table daily because we are not following the recommendations that we already know work," Calonge said. "If we put the resources into doing blood pressure screening and lipid screening and then follow it up with the appropriate therapies, we would save so many more lives than we would by incorporating CRP, ABI, or CAC." □

Safe Vaccination Usually Possible in Persons With Suspected Vaccine Allergies

Mike Mitka

INDIVIDUALS WHO HAVE AN ALLERGIC reaction after receiving a vaccine may be able to safely receive that vaccine again in the future provided proper precautions are taken, according to recommendations laid out in a new guideline released October 8.

The guideline's authors said that physicians should strive to overcome allergy-related issues surrounding a particular vaccine, not only to protect the individual from certain infectious diseases but also to reduce the risk of infection in the general population. The guideline, *Adverse Reactions to Vaccines*, was issued by the Joint Task Force on Practice Parameters, a group representing the American Academy of Allergy, Asthma and Immunology; the American College of Allergy, Asthma and Immunology; and the Joint Council of Allergy, Asthma and Immunology (Kelso JM et al. *Ann Allergy Asthma Immunol.* 2009; 103[4],[suppl 2]:1-14).

The authors noted that immunization is safe and that anaphylactic reactions to vaccines are rare, occurring at

a rate of about 1 per million doses. Adverse reactions following most vaccinations are mediated by immunoglobulin E antibodies and are most often caused by vaccine components, such as gelatin or egg protein, rather than the immunizing agent itself.

According to the guideline, an allergist or immunologist should evaluate patients with suspected allergy to a vaccine or vaccine components by assessing immunoglobulin G (IgG) antibody levels following administration of the vaccine that caused the allergic episode. If IgG antibodies are at protective levels, the patient can avoid receiving subsequent doses; if the patient lacks protective IgG levels and future vaccination is required, the guideline recommends administering the vaccine in graded doses under observation. For example, if a usual vaccine dose is 0.5 mL, escalating doses (eg, 0.05 mL of 1:10 dilution, 0.05 mL of full strength, 0.10 mL of full strength, 0.15 mL of full strength, and 0.20 mL of full strength) should be administered at 15-minute intervals.

The guideline noted that following vaccination, mild local reactions and

constitutional symptoms such as fever are common and do not contraindicate future doses. However, for patients with a history suggestive of an anaphylactic reaction, the guideline said that administering vaccine under observation, with epinephrine and other treatments available, is prudent.

In addition, the guideline warned that live vaccines should not be given to individuals who are immunocompromised because such vaccines pose a risk of generalized infection with the immunizing agent. Likewise, pregnant women should not be given a live vaccine, but they should receive inactivated influenza vaccine, as well as tetanus and hepatitis B vaccines if otherwise indicated.

The authors added that all serious adverse events following vaccine administration should be reported to the Vaccine Adverse Event Reporting system (<http://vaers.hhs.gov/esub/index>). They also reminded readers that epidemiological studies have not supported claims that specific vaccines or vaccination in general have such long-term consequences as atopy, autism, and multiple sclerosis. □