## SESSION 1
## Viral Infections in IBD

# PREVENTING INFECTION IN THE ERA OF BIOLOGICS

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Modern day therapies for IBD can put patients at risk for infections, including vaccine-preventable diseases. Prevention of infection is critical for immunosuppressed IBD patients. In general, vaccinations received during childhood and adulthood should be reviewed at the time of IBD diagnosis. Inactivated vaccines include influenza, pneumococcus, hepatitis B (HBV), and human papillomavirus (HPV) vaccines. To achieve optimal immunogenicity, inactivated vaccines should ideally be given at least two weeks prior to initiating immunosuppression or at the nadir of immunosuppression. Titers are not routinely available for most vaccines except HBV; therefore, timing of vaccines in patients on biologics and other immunosuppressives is an important factor. Live vaccines include measles, mumps, rubella (MMR), varicella, and shingles vaccines; these can be given prior to initiating immunosuppression. Viremia may, however, occur after vaccination; therefore, a period of three to four weeks should elapse before initiating immunosuppression. Although live vaccines have generally been contraindicated while on biologic therapy, there are emerging data to suggest safety of live shingles vaccination in patients receiving biologic therapy. Beyond vaccination, immunosuppressed IBD patients are also at risk for infections. Screening for HIV, HBV, hepatitis C, and tuberculosis (TB) should be performed for those initiating biologic therapy. Persons on biologic therapies are at specific risk for opportunistic mycobacterial, Nocardia, and fungal infections. Pneumocystis prophylaxis should be considered for those on high-dose steroids or triple immunomodulatory therapy. Latent TB infection should be treated. Patients with fever should undergo urgent evaluation.

### References

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