

VARICELLA



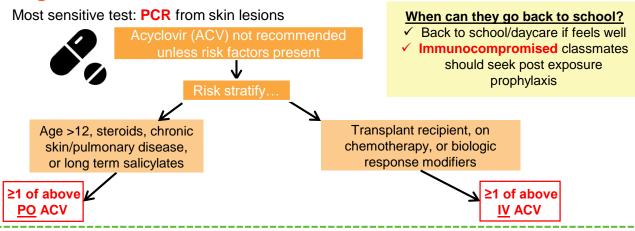
Clinical Presentation

- Prodrome: fever, malaise, anorexia, headache
- Rash is widespread, pruritic rash, erythematous macules which progress to blisters that crust over
 - Rash is not uniform, lesions at different stages of healing, centripetal distribution
- Most common complication is secondary bacterial infections from group A streptococcus, Staphylococcus aureus
- Reactivation of latent infection decades later resulting in Herpes Zoster (Shingles). Rare in healthy children, often history of chickenpox or vaccine, rapid recovery.

Pathogenesis

- Transmission: respiratory or oral secretions
- Stays **airborne** for many hours, may be acquired from being in the same room as an infected person
- 1st viremia (prodrome symptoms), 2nd viremia (widespread rash)
- Breakthrough varicella: mild form (<50 lesions), most often after only single dose of vaccine
- Replicates in lymphoid tissue. Virus remains latent for life in a dorsal root ganglion
- Virus can reactivate at any point, especially if the person becomes immunosuppressed

Management



Prevention

- ✓ Prevention through vaccination
 - Live Attenuated Vaccine given SubQ in 2 doses (12 months then at 18 months or 4 years)
 - Contraindicated if: previous anaphylactic reaction, pregnancy, immunosuppressive therapy, leukemia/lymphoma

Who gets a post exposure prophylaxis (VZIG)?

- 1. <u>Immunosuppressed</u> patients (VZIG but may use vaccine in lower risk cases).
- 2. <u>Premature</u> babies (<28 weeks).
- 3. <u>Newborns exposed</u> to varicella (5 day pre-delivery to 2 day post-delivery).
- 4. <u>Pregnant women without evidence of immunity to varicella.</u>
- * Note on neonatal varicella: consult infectious disease. Management is complicated.

Published November 2020

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