The Canadian Society of Allergy and Clinical Immunology
La Société canadienne d'allergie et d'immunologie clinique

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STATEMENT: ADMINISTRATION OF H1N1 AND SEASONAL INFLUENZA VACCINE TO EGG ALLERGIC INDIVIDUALS

The safe administration of influenza vaccine to egg allergic individuals has become increasingly important with the pandemic planning for H1N1 influenza. Since the H1N1 vaccine and the seasonal influenza vaccine are grown in fertilized eggs, there is a theoretical risk of allergic reactions in patients with egg allergy. The benefits of vaccination with H1N1 and seasonal influenza are great, given the potential serious nature of these illnesses. This risk of a serious allergic reaction appears to be very low and the literature suggests that it might be safe to administer this vaccine to these individuals. The goal of this statement is to ensure that those patients with egg allergy can receive both influenza vaccines provided risk reduction procedures are in place.

This statement is for physicians of patients with a diagnosed egg allergy who are candidates for the influenza vaccine (both H1N1 and seasonal). Tolerance to one vaccine does not eliminate risk of a reaction to the other vaccine, and there can be significant lot-to-lot variability. Egg allergy is defined as immediate symptoms within 1 – 2 hours after exposure, such as urticaria and angioedema, respiratory, gastrointestinal, or cardiovascular symptoms plus confirmatory allergy tests (skin test or egg specific IgE). We have subdivided the patients with egg allergy into **lower risk** (mild gastrointestinal or mild local skin reaction, tolerating ingestion of small amounts of egg, or positive skin/ specific IgE test to egg without knowingly exposed to egg), or **higher risk** (previous respiratory or cardiovascular reaction, generalized hives or those with poorly controlled asthma).

The risks of potential reactions should be discussed with the patient. If the vaccine is administered, a physician must be present and access to emergency treatment, including epinephrine, must be available.

For patients in the lower risk category, the vaccine can be administered, but the patient should be observed for 60 minutes. For patients at higher risk, or if the risk is unknown, we recommend an initial test dose with 10% of the total dose followed by 30 minutes of observation. If there is no reaction after 30 minutes, the remaining 90% can be given and the patient observed for 60 minutes. Children who tolerate the split dose and who require a second dose (1st time receiving influenza vaccine) can receive the next dose in one injection. Note that tolerance to this year's influenza vaccine does not guarantee tolerance to other years' and does not guarantee tolerance of the H1N1 vaccine. The same approach is recommended for each vaccine. Again, we would like to emphasize that the risk of a serious allergic reaction appears low.

Allergists are trained to recognize and treat anaphylaxis. Whenever possible, egg allergic patients, particularly those with recent or severe reactions, should be referred to their local allergist for influenza vaccine testing, if indicated. The allergist will then make a decision, based on history, skin tests or specific IgE results, if the vaccine should be given as a single or multiple stage injection.

The CSACI recognizes that other approaches for the vaccination of egg allergic individuals with the seasonal flu vaccine are available, and that the above recommendations do not preclude the use of other approaches.