Isabel Valdez (00:01):

Hello and welcome to Optimizing Immunization Practices, your Role, your Impact, a podcast series brought to you by the American Academy of Physician Associates and the France Foundation. This activity is supported by independent educational grants from Pfizer and GSK. This podcast series focuses on how you can optimize adult immunization in your practice. In this episode, we will focus on shingles and discuss the disease burden, the current immunization rates, the recommendations and strategies to increase vaccine uptake. As always, we will share resources that you can use in your practice. I am physician assistant Isabel Valdez, assistant professor in the Department of Medicine at Baylor College of Medicine in Houston. And today our expert in all things vaccines, liaison for AAPA and all things vaccine. Our powerhouse right here, Ms. Sarah McQueen. Sarah, I hope I did you right with this introduction and beat Snoop Dogg.

Sarah McQueen (01:03):

Isabelle, that was amazing. I'm definitely going to take snippets of this and play this instead of my morning affirmations by Snoop Dogg. So I am a PA in family medicine at FQHC. We do rural health. We have a school-based health center. I go to the nursing home and I love talking about vaccines. And so I think we are all familiar and scared of shingles. So I am excited to talk through this with you today.

Isabel Valdez (01:28):

Yeah, I know I am afraid of shingles. I can't wait till I turn that beautiful age. I'm almost there 50, and I say for my birthday, I'm going get my shingles vaccine. And I really do tell patients that because I don't want shingles. It's a mean infection. In fact, it is a viral infection that can cause a really painful rash, and it's caused by a reactivation of the vari cell zoster virus. Big old, like the one we know is our favorite chickenpox. And we all got those chickenpox parties, and if we didn't, we got the shot. But after a person recovers from chickenpox, this virus remains dormant in the body, in the dorsal root ganglia and the cranial nerve ganglia. And it can get reactivated later in life leading to shingles. The affected population is pretty much anyone who's had chicken pox, and we probably know a lot of people, if not everybody has.

(02:16):

So from chicken pox, they can develop shingles, but the incidence increases in adults over the age of 50. It can also affect our vulnerable populations such as patients who have or are diagnosed with HIV who live with HIV patients with cancer, and those with immunosuppressive medications, women are equally as likely as men to have ever received this shingles vaccine. So this is good news. About 35% women have received the vaccine and 33% for men. So this is great, and this is information based on a 2020 study by the National Center of Health Statistics. But we can do better, and this is actually why we're here today, to learn those strategies that can help us and be advocates for this vaccine with our patients. And the CDC estimates that one in every three persons in the United States will have shingles in their lifetime. So that's one too many patients getting shingles infection because what we're worried about is the postherpetic neuralgia. So can you tell me about that disease burden? You've probably seen it in clinic, the shingles, and you've probably seen postherpetic neuralgia too. What's been your experience in family medicine?

Sarah McQueen (03:21):

It is. It's something that I don't think gets enough attention. And I think even sometimes we see patients come in, maybe they just come in for pain that they have, and it's in a weird dermatome location and we go, huh, maybe that's interesting. Let's get an MRI see if that's a disc, and then everything is normal, and

so perhaps we're seeing a lot more of these and we just forget that, oh, we had shingles there. Or sometimes it's even the classic. So usually what happens with shingles and family medicine is they come in with the pain, you look no rash. Oh wow, I don't know. Try some of these. Try heating pad ice, all that. Come back if it gets worse, well then two or three days later, the rash hits, they've got low great fever body aches. So they go to the ER and they go, duh, you have shingles, your family practice provider's an idiot.

([04:11]()):

And we're like, well, if I would've seen a rash like that, I would've diagnosed shingles too, because we're all familiar with that blistery rash. But the worrisome complication is this postherpetic neuralgia. And what's interesting is 10 to 18% of people with shingles have this risk of developing this, and it is a prolonged pain and disability and the risk increases with age of that. You're going to develop this. But I have had several patients who for 15 years would have some level of constant underlying pain, but then would have these flareups of just severe like, oh, it's really intense. And so it's something that causes just a lot of issues. And I think we overlook that of it's not just the itchy painful rash that goes away after a while, but it is this condition that can be permanent and it can be debilitating. And there are also those rare cases of shingles that, especially in immunocompromised, it can cause some strange pneumonias and even some neurological conditions.

([05:19]()):

And so folks get hospitalized with shingles. It's very, very rare, but it does happen. There is a mortality associated with shingles, but that is rare. But this postherpetic neuralgia is not. It's something that we really need to talk to and consider. And then we all know that location matters, location, location, location. So if it's on the face, that is when we all go, oh, you've got to see an ophthalmologist today. And when we're on the phone, making sure we can get them in and making sure that we're treating them with antivirals and all those things because that can cause vision and hearing loss, any shingles that's on the face. And so that is still the, if you see it there, they need close follow up. Talking about the economic impact too, is people miss work because they're in pain, they have an uncomfortable rash and it's goopy. In cases, you have folks who are in the public and say, it's more rare on the arms and extremities, but if you have this visible, oozing, weeping rash, you're not going to go to work and it's painful. So it does cause missed time at work, and it's just one of those things that nobody wants. For sure. What are some things that you've seen in your practice?

Isabel Valdez ([06:35]()):

Well, when I was in family medicine, I remember that we had this one coworker who hadn't had chicken pox. So I'm the one that my colleagues would say, well, Isabel's got an opening and she's had chicken pox. So you go, so here I am. Right? Because we had, again, we're trying to protect our coworker who had not had chicken pox, and there was this other time that same thing, but it was a pregnant patient, a pregnant provider. So one of our pregnant providers, we had to protect her. So if a patient was, there's a suspicion of shingles and it was on her schedule, we would move the patient to somebody else's schedule because we were trying to protect her so that she would be fine. But our concern was with her pregnancy. So that was my experience too, as well as everything you said, the pain can linger, it's debilitating, have to miss work for several weeks.

([07:30]()):

Not to mention also just it doesn't really leave a scar, but you're right, if it's in your face or something that's public facing, you may want to skip out on being seen because of your concern about your appearance. And that makes complete sense, and it's a vulnerable position to be in. So everything that you've said, I've seen it in clinic too. And this is one of those that I'd rather err on the set of caution and

just get ready and treat if there's a slight slightest concern for it, because you're right, the rash might come up later. So equipping the patient with, if you get that funny rash in the next 24 to 48 hours, I want you to start this medication because I'd rather you have the tools at home to treat this than not and end up in the er. And sure enough, within four to three days later, they said I had to start the medicine.

(08:25):

And then they send me a picture in their electronic portal like, yep, nope, that's the rash. Because sometimes it'll trick us because you'll get the pain first and the rash later. So these are experiences that you and I can commiserate for hours, but we don't have hours today to tear that. Now the current immunization rate for this is it seems like we could do better, right? Because in order to have good immunity, it's anther in between 70 to 90% is considered good. Now with shingles, we don't haven't had a good number of vaccinations. This is only about 34% of the adults over the age of 60 have gotten the shingles vaccine. And this is a remarkably low number considering how we have a great vaccine that it has great outcomes. The recombinant zoster vaccine, it's commonly known as Shingrix. I mean, it's such a great shot. What's been your experience with the Shingrix vaccine and what's the education you give to your patients to get them to buy into the vaccine?

Sarah McQueen (09:23):

So I think we've had this shift both in the past few years of ages when this was recommended, but then also the actual vaccine itself. And so now we have Shingrix as the only available shingles vaccine in the US, and it has replaced the zoster vaccine. So if you look at this, the number from the CDC, about 34% of adults over 60 have received the shingles vaccine. You think why? And you think, well, how many of our patients under the age of 60 have already had shingles? And so are they thinking, well, I've already had shingles. I don't need this vaccine. But I've seen shingles happen more than once. And I think that used to be the old education of, oh, once you get shingles, you won't get it again. But we do see that, and especially in immunocompromising conditions, you get folks that just have shingles over and over again.

(10:11):

And so it's part of that education of, look, I know you've already had shingles, but let's get this vaccine because Shingrix is fantastic at preventing shingles and preventing the severe complications of shingles. And so it's so good in fact that our folks that were vaccinated with Zostavax are supposed to get vaccinated with Shingrix because of weighting immunity of the Zostavax. And so we really need to do better at telling our patients of, look, I know you already had this shingles vaccine. I know you've already had shingles. I know that you feel for some reason you may not be at risk for shingles, but this vaccine significantly, I mean it is more than 90% effective. And so it's fantastic. It's a great tool. And I think another issue is, so I see all the time on social media of, well, I'm immunocompromise. I can't have vaccines. And I'm like, whoa, whoa, whoa. No sister immunocompromised. You need all the vaccines, lots of vaccines. And so that's a play too, is we really need to look at our population and making sure that we're recommending this because this can be really devastating. And so just letting people know of, look, you need this, even though you had the old one, let's do this.

Isabel Valdez (11:25):

I think it's beautiful. That's such a good number to, it's easy to remember 90% effective at preventing shingles and the complications like the postherpetic neuralgia. I love that you just told us that because that's such an easy number to remember. And I feel like that's a really good selling point for this vaccine and for the protection of it because, and educating the patient, it's not just the infection that we're helping you with, it's the pain that comes from it. And for every patient that I've seen who's had without

the vaccine, they said, I wish I got the shot and just I passed that on as education and it's like, please learn from my experience that I'm doing. It's a vicarious experience that I have from patients who've had the infection, they wish they'd gotten the shot. So the sooner you get it, the better. So I love that you say that, and I think you started to talk about some of the recommendations, right? Because we have this fantastic vaccine, the shingles vaccine, but can you tell us more about the recommendations for that one at this point?

Sarah McQueen (12:22):

So now our target population is 50 years and older, and we used to, I will text my cousin like, oh, this is your mammogram birthday. Oh, this is your colonoscopy birthday. And so that's changed a little bit, but now this is your shingles birthday age 50 and so start, and my cousins are older than me, so they think I'm hilarious, I'm sure. And so this 50 and older is that sweet spot now that we do Shingrix. And now this is a two dose vaccine. It's given anywhere between two and six months apart. The minimum interval is about four weeks. Now when that comes into play is say you have someone that is about to start treatment for say cancer or some kind of treatment that's going to be compromising, you may want to make the decision to give that vaccine a little bit earlier. And so that's why there's a little bit of leeway.

(13:14):

You have to wait four weeks, but you can do it anywhere between two and six months. Now, say you have something, somebody that forgets after six months and they're over 50 and they don't come in, but once a year for their annual, it's fine. You don't have to restart the series. You can give them that second dose when they come in, but you really want to shoot for come back in two to six months and let's get that other dose. But it's okay if they miss that. And this is not a seasonal vaccine. You can get shingles at any time. And so this is one to really recommend at any opportunity that you have. Now there are a new or recognized special population, and that's the immunocompromised that are 19 and over. If they're immunodeficient or immunosuppressed, it's actually recommended for 19 and over can get Shingrix. And so this is fantastic news for those folks that are at risk for getting shingles and getting a severe case that they can get this vaccine now too. And so I love these recommendations. I think 50 and over is fantastic to start this.

Isabel Valdez (14:24):

I love that you just reminded me of the immunocompromised population. I think this is so important. And just in full disclosure, my population happens to be either older adults or immunocompromised. That's like my two big buckets of patients having this new tool of information that they can start getting their vaccine for the immunosuppressed specifically over the age of 19. That's a huge cohort of patients that I can start now recommending the Shingrix vaccine to. And right now we want to improve the vaccination uptake. There are some barriers to it, and the barrier that I face in my practice is that we still haven't gotten it. So what we've done in our clinic is we write a prescription for the patient and we send it to their pharmacy. That way it serves as a reminder to the patient and to the pharmacist. Like, Hey, the pharmacist will see this picture. It looks like your doctor prescribed the shingles vaccine. You're like, oh yeah, I was supposed to get that. And that right there might close the gap a little bit in that vaccination rate. So what other barriers have you encountered in family medicine? What have been some of your approaches to help narrow dose gaps in vaccination?

Sarah McQueen (15:33):

So a lot of it is just lack of awareness. People still get this, so that's an older adult vaccine. And so it's talking to 'em like, Nope, it's time. And so it's really just having that education of you are 50, now we're

going to add this to our list of checking off those boxes of mammogram, colonoscopy, all of those things. And so that's the big key is maybe you want to, if your practice has a social media presence, do a big 50 shingles so that way they're equating that number to get them in and are aware of that. Everybody I think is worried about out-of-pocket costs because 50 to 64, that's before you can sign up on Medicare. And so that is a group that depends on either insurance through their workplace or however they get their insurance, or maybe they don't have their insurance.

(16:30):

So sometimes it's looking into those resources. There is three 17 funds that are available that offers free vaccines to adults. Each state kind of has their own program name for when they receive those funds and then disperse it. Our states still call it BFC even though it's not for children. And so there are those programs out there to make sure that folks without insurance or even some folks have insurance but not vaccine coverage or it doesn't cover all the vaccines or they have a high deductible plan, those types of things. And so there are programs out there that help with that. And so it's just getting someone at your clinic that's looking at community resources, state resources to get these folks coverage. I think I don't really see a lot of hesitation with the vaccine in terms of not believing the severity of the disease.

(17:21):

I mean, you say shingles and everybody's like, whoa, gosh. And so that's not a hard sell for me. I think a lot of it, it really is just age. I think people have heard the side effects of the vaccine can be feel kind of crummy, body aches and that kind of thing with this one. And so that is kind of like, I've got a lot to do this weekend. I don't have two or three days to nurse this on the couch. And so then it's really encouraged 'em of like, look, come back when you have a few days. I say, so for some reason I do a lot of toenails in my practice. All the other folks in my practice hate touching feet. And so I get their toenail removals, whatever, so it's fine. And so I'll say, look, come back when you've got a few days.

(18:05):

They don't have to work because you're going to have to nurse this toe. And so I'm like, look, it's like with any procedure that you have, you just need to prepare for it. At least you're not drinking all of the mag citrate for a colonoscopy. At least you're not spending two days on a toilet. You can just stay home, watch some Netflix or whatever. And so just really trying to talk through of like, look, I get it. I understand that you don't want to feel like garbage, but this is going to prevent you from getting shingles, which is most important. So just talking through those experiences and really highlighting the postherpetic neuralgia and how it can be disabling. I mean, folks have to quit their jobs or patients that I've seen that had it on the face, they couldn't go out in the wintertime because cold air when it hit that spot just lit it up. And so these are things that really can affect life. So just stressing those things is really all that I've found that I have to do with my patients.

Isabel Valdez (19:04):

I love how you just said, just plan ahead because this is one of the vaccines that I do prepare my patients for. I anticipate them. So I'm giving them, my spiel is you may feel pretty ill after they take this one. This one really packs the punch in your immunity and that tells us it's working. And just like you used to have chickenpox parties, well now you're going to have a shingles party at home. You end of one watching Netflix and lots of, well, not lots of popcorn because watch your salt, your blood pressure will go up. Of course, the PA and me is going to tell you not to do that and no sugars, but just enjoy Netflix and rest. It's time for you to rest. But the idea that it's a couple of days out of your whole life for recovery, if you even get any side effects from the vaccine versus days, two weeks to months from the postherpetic neuralgia that can debilitate you, get you out of work and whatnot. So I think once we weigh those two, you have to reconcile those two with patients. I think that'll help with making that informed decision for

some of our folks. So I think it's such a great point that we're making today, and I think these are strategies that you've used that you've used in clinic. I'm sure you have more. What other strategies have you used to help with the vaccine uptake for shingles?

Sarah McQueen (20:23):

So evidence shows that a strong recommendation from a provider is one of the most important things in getting anyone making a decision on vaccines. So I think that comes from us as making sure that we understand how important it's so that we can make a true, genuine, strong recommendation for it. And I think that also comes in with making that our nursing staff, they understand because they're the first line, they're the ones that get the questions at the supermarket. I mean, we get 'em too, we just do. But so making sure everyone as a clinic understands and can make that, because if, I don't want to say we wear patients down, but you have the nurse that talks to 'em about the shingles vaccine, then a provider talks 'em about the shingles vaccine. And so the more it's mentioned, the more likely it is. So treating every visit like a vaccination visit, empowering your nurses to have a standing order so that they just give vaccines that are needed without having to wait for you if your institution doesn't have the vaccine available, making sure that there's something that you're giving them, whether it's a prescription, whether it's as simple as a piece of paper, writing it down as simple as immunized.org will print off vaccine records for adults.

(21:39):

And so then you can show them that, Hey, you got your flu shot this year, but you didn't get this, this, this, this. And so something, as they're looking at their garbage in the bottom of their car cleaning it out, they'll go, oh, I need this vaccine. And so it's all these little things that little reminders, but more importantly, that strong recommendation from the provider is so important. Working with local pharmacies and just making sure that folks are ready for those side effects of the vaccine is really how we do it.

Isabel Valdez (22:13):

I think these are great strategies. I love that. The idea of incorporating the entire team. It's their medical assistants, your nurses, your pharmacists. It's a team approach to help, like we've said it before, it takes a village to help reduce the incidence of this, the postherpetic neuralgia, which I think a lot of people might not experience. I think that people know or like, oh, my friend had shingles and it really hurt. And then that's the point at which I capture the patient like, yes, that's the hurt that I'm trying to prevent. Your friend told you you're hurt. That hurt times three weeks, times four weeks. That's the hurt that can last. The postherpetic neuralgia, that's what we're trying to prevent, 90% preventable with the vaccine. And once they have that, because if they hear from someone, they know one, they hear that this is a bad disease, and two, they hear it from us that there's a way to prevent it because you're absolutely right. When they hear things from us, we are pretty powerful. They see us as we're on their corner where they're advocates. So I hope that this helps us, empowers us as we advocate this vaccine to our patients. So what other takeaways can you share with us as we close out this discussion on such an important vaccine?

Sarah McQueen (23:24):

So I think just remembering this vaccine can be grouped with other vaccines. There's not a contraindication. You can give this with your RSV, your tdap, your influenza, your covid. These can all be given together at the same visit. And so that is really important, making sure that we're decreasing visits and strain on access to care. And so I also think it's really important for us to remember, you can get and

give the vaccine even after someone has shingles, even up until as soon as they're recovering from a shingles infection, as soon as they've recovered, you can give them the shingles vaccine to prevent another case. But then also remembering that if they've had the old vaccine, the Zostavax vaccine, please give them this newer vaccine, the Shingrix, because it's going to offer the best protection because it is just, we know that there's waning immunity, and so making sure that we're recommending this when our patients feel well and they have time to recover. And so just making sure that everybody needs a shingles vaccine essentially. That's what we're saying, right, Isabel?

Isabel Valdez (24:29):

Absolutely. As soon as you turn 50, I can't wait. Everybody over the age of 50. Absolutely. You have given us a lot of information. Every visit is a vaccine visit, is what you said before, and I think that's so important. And just a simple way of looking at clinic every day, every visit is a vaccine visit. You are such a great advocate. You speak so well on the importance of vaccination and you are empowering us, your PA community. I'm so grateful that you've been able to teach us this today and in the other episodes that we've talked about vaccination. So thank you, Sarah. It's a wealth of information that you've given us, so thank you so much for empowering us. We have to now just protect our patients from the shingles infection, and we can do that by prescribing the vaccine if we don't have it in clinic or just giving it today because your recommendation matters as your provider. Thank you again for listening to this episode of Optimizing Immunization Practices, your Role, your Impact. Please tune in to the other episodes in this series where we provide an overview of adult vaccinations and discuss vaccination specific information for covid, influenza, tetanus, diphtheria, and pertussis and respiratory syncytial virus. You can find a full list of the podcast episodes on aapa.org. I'm physician assistant Isabel Valdez, assistant professor at Baylor College of Medicine in Houston. Thank you so much for joining us, and you can catch us on aapa.org.