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INDICATION ▶		Immunocompromising conditions (excluding human immunodeficiency virus [HIV]) ^{1,2,3,4}	HIV infection ^{5,6,7,8} CD4+ T lymphocyte count	Diabetes, heart disease, chronic lung disease, chronic alcoholism	Asplenia ^{9,10} (including elective splenectomy and persistent complement deficiencies)	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Health-care personnel	
VACCINE ▼	Pregnancy	<200 cells/ μ L	≥200 cells/ μ L						
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1,4}	Td	Substitute one-time dose of Tdap for Td booster; then boost with Td every 10 years							
Human papillomavirus ^{2,7}		3 doses for females through age 26 years							
Varicella ^{4,8}	Contraindicated	2 doses							
Zoster ⁴	Contraindicated	1 dose							
Measles, mumps, rubella ^{5,6}	Contraindicated	1 or 2 doses							
Influenza ^{6,7}		1 dose TIV annually							1 dose TIV or LAIV annually
Pneumococcal (polysaccharide) ^{7,8}		1 or 2 doses							
Hepatitis A ⁹		2 doses							
Hepatitis B ^{10,11}		3 doses							
Meningococcal ^{11,12}		1 or more doses							

¹ Covered by the Vaccine Injury Compensation Program.
 For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)
 Recommended if some other risk factor is present (e.g., based on medical, occupational, lifestyle, or other indications)
 No recommendation



Table 3. Recommended Adult Pertussis Vaccination Schedule

Population	ACIP Recommendation for Tdap Administration
Persons 19-64 y	As soon as feasible; may be 1-time substitute for recommended 10-year Td booster
Persons ≥65 y	Boostrix preferred; however, do not delay if Boostrix unavailable
Pregnant women	During 3rd trimester of each pregnancy; if not administered during pregnancy, vaccinate immediately postpartum
Healthcare workers with direct patient contact	As soon as feasible if Tdap not previously received in adulthood; priority for those in direct contact with infants aged <12 mo

ACIP: Advisory Committee on Immunization Practices; Td: tetanus-diphtheria toxoids; Tdap: tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis. Source: Reference 13.

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Therefore, a high rate of vaccination must be maintained to protect the population from the resurgence of the disease. National Capital Impression: Canberra.PERKINS S, CORDERY R, In this case, repeated swabs may be considered on a case by case basis. Arranged at accessed 6/5/10/2011.OUSEAU C, Belchior E, Broocha B, Badell and, Giso N, Laharie I, Patey O , Wool E vy-bruhl D. 2008.The immunological base for the immunization of; Diphtheria-Module 2. For most of these cases, there was a van with the trips abroad. Clinical evidencies - probable case and epidemiological evidence. The scoring of the full review of these guidelimes was carried out in 2018 due to the increase in the notifications of toxigations Cutneas C. I attend the vaccination against vaccination against the diphtheria, referring to -If records are disposedable. Difteria farãngea at © 2 throat and nose cultures (and skin lesions), no less than 24 hours, and no less than 24 hours after antimicrobial therapy interruption, fail to show C . 2004: Control of manual transferable disease, 19th edition. Of the publicity of the communicable dis. Ulceran isolates are tracked to the nucleo -projected dipteria toxin (NAT) to detect the tox -encoded diphtheria toxin gene. Diphtheriae (Diphtheria Cutã ¶ Nea). Infections in other places, including the bloodstream, endorsened, bones and articulations are almost invariably caused by C. not toxigenic, mainly to identify if any potential exposure is probably dripping would occur. For example, drops can be generated by washing the wound or irrigation of the wound vigorously under pressure. All contacts must have their immunization history. All contacts, as defined above (except for the Workers who had a brief contact with the wound while wearing gloves and did not perform procedures that probably generate droplets) should have nasophardic swabs and throat. These should be done before the innate of the antibiotics where this is applicable. If asymptomatic contacts return a positive swab nasophard or throat, they should be managed as asymptoms (see the box c à à € "" nasofarãngeal stomach - under the breathtaking section of these Guidelines. All contacts, as defined above, require off -break antibody except: Travel companions who are asymptomatic and also fit another categoryhealth assistant category or others who had a brief people Contact with the wound while wearing gloves and did not perform procedures that probably generate droplets. Annex C for antibody and recommended dosages. Receive a dose of reinforcement of diphtheria toxion if more than 5 years had elapsed since the last dose. Difteriae at a low aircraft, especially for vain less than 8 hours of duration. Usually, there is no need to contact the adjacent seats in the following circums Tonscia: Someone later diagnosed with respiration diphtheria traveled in a long distance vain during the incubation period. Some Diphtheria and Nasopharynx Sorery Swabs and Negative Shore Swabs traveled by a long distance. Swabs Nasofaman initial and/or throat. Special efforts should be made to ensure that people with the highest risk of exposure, for example. Corynebacterium Diphtheriae and the Returned Tropical Traveler. If you take the IM antibody for 10 days would complete treatment with additional 4 days of antibiotic Po) 2 Use a lower dose in children

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