Varicella-zoster virus (VZV) poses a significant disease and economic burden. The primary VZV infection results regularly in varicella (chickenpox), which has been considered one of the most common vaccine-preventable diseases in many countries. Whereas the clinical course of varicella during childhood is usually mild and self-limiting, persons over 15 years of age and immunocompromised patients tend to have more severe diseases with a higher rate of complications. During pregnancy, chickenpox can be associated with disastrous illnesses for both the mother and her neonate. This has led several nations worldwide to consider a universal infant vaccination program. Thus, varicella vaccination has been incorporated into the routine immunization schedule of infants and adolescents in the developed industrial countries such as the United States, Canada, Australia, Japan, South Korea and Germany.[1,2]

Seroprevalence studies performed in different countries with temperate climate revealed that the prevalence of VZV-specific IgG class antibodies shows rapid increase during the first decade of life and reaches more than 90%. Among those more than 40 years of age, only isolated individuals are susceptible to VZV.[3] In tropical and subtropical regions, a relatively small portion of children has been demonstrated to be VZV-seropositive, and varicella has been shown to affect mainly adolescents and adults.[4] Women from such countries are more likely to be seronegative for VZV IgG and are therefore more susceptible to the development of chickenpox.[5] Thus, chickenpox in tropical and subtropical regions may result more often in complications, including death. The differences found in VZV seroprevalence may reflect variations in virus transmission between temperate and tropical climates.

In principle, there is a general lack of epidemiological data about VZV infections in developing countries as well as in regions with desert or tropical climates. Therefore, the manuscript entitled ‘Seroprevalence of varicella-zoster virus infections in the Colombo district, Sri Lanka’ is welcome for publication since it provides important information about the VZV seroprevalence in Sri Lanka.[6] The present data may help to understand differences of VZV infection between tropical and temperate regions and may support the decision of the responsible public health authorities to introduce varicella vaccination in this country.

REFERENCES