

Vaccination against Bacterial Infections

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Assuring the quality of biological medicines

Overview

- Background on host defences and how this relates to vaccination
- What's in a vaccine formulation?
- Different types of vaccines
 - Toxoids
 - Conjugates
 - Live attenuated
 - Killed whole cells
- New vaccines

Host defence against infectious agents

- **Innate immunity**
 - First line of defence
 - Does not require exposure to the infectious agent
 - Is immediate (almost)
 - Mediated by monocytes and PMNs
 - Initially an inflammatory reaction
- **Acquired immunity**
 - Requires exposure to infectious agents
 - Takes time to develop
 - Mediated mainly by lymphocytes (B and T cells)
 - Other cell types involved, e.g. monocytes and dendritic cells

Host immunity can be broadly divided into two types: innate and acquired immunity. Vaccines stimulate both aspects of the immune response but are primarily aimed at eliciting acquired immunity which requires exposure to the infectious agent or its antigens.

Acquired immunity

- Humoral Immunity
 - directly mediated by antibodies
 - antibodies are produced by B lymphocytes
 - Plasma cells (terminally differentiated B lymphocytes) are the primary source of secreted immunoglobulins
- Cell Mediate Immunity
 - not primarily mediated by antibody
 - mediated by T lymphocytes and NK cells
 - indirectly other cell types may play a role e.g. macrophages

Acquired immunity can be divided into two arms: humoral immunity which is mediated by antibodies and cell mediated immunity. It is important that a vaccine stimulates an appropriate immune response. For example, humoral immunity is usually important for preventing septicaemia whereas cell mediate immunity is often important for the prevention of intracellular infections. They are not mutually exclusive with both elements of the immune response playing a role in protection against many diseases.

Immunity to bacterial infections

- Role of antibody
 - Toxin neutralisation, e.g. tetanus, diphtheria, botulism, anthrax etc.
 - As a focus for complement binding
 - As an opsonin promoting phagocytosis } Ab mediated bactericidal activity
- Role of cell-mediated immunity
 - Particularly important for eliminating intracellular bacteria, e.g. tuberculosis, typhoid, legionella
 - interaction of the reactive T lymphocytes and the macrophage is key to clearance of infection
- In reality protection will often be the result of a combination of humoral and cell mediated immunity

Many bacteria produce exotoxins that have significant effects on the host, e.g. tetanus, botulism, cholera, anthrax, diphtheria, whooping cough etc. Their effects can be neutralised by antibodies binding to active sites or resulting in antibody antigen complexes.

Invasive bacteria and bacteria infecting mucosal surfaces do not always produce exotoxins. Protection against such infections is often mediated by antibodies that kill the bacteria through the classical complement pathway or opsonisation.

Bacteria like *M. tuberculosis* are intracellular pathogens. In this case, protection and the clearance of infection is primarily mediated by cell mediated immunity.

In reality, although we tend to reduce the immune system to neat categories, protection against most infections will depend on several elements of the immune response. For example, the initial invasive steps of an infection may be susceptible to an antibody response but subsequent clearance requires a cell-mediated response.

Properties of a good vaccine

Ideally a vaccine:

- Stimulates an effective immune response
- Is safe and does not cause adverse reactions
- Is inexpensive to manufacture and distribute
- Is stable
- Is easy to administer
- Should be simple for both manufacturer and regulatory authorities to control
- **i.e. a good vaccine provides substantial benefit to health at low cost and low risk**

In many respects these are common sense points.

To be effective an immune response should be appropriate to the disease in question.

- It should elicit the correct balance of humoral and cell mediated responses
- The immune response should be directed to the relevant site within the host (e.g. the gut in the case of enteric infections).
- The immune response should be “functional”. For example, toxin-neutralising antibodies should be able to bind to toxin and neutralise its activity or if bactericidal antibodies are required the antibody should bind both the bacterium and complement.

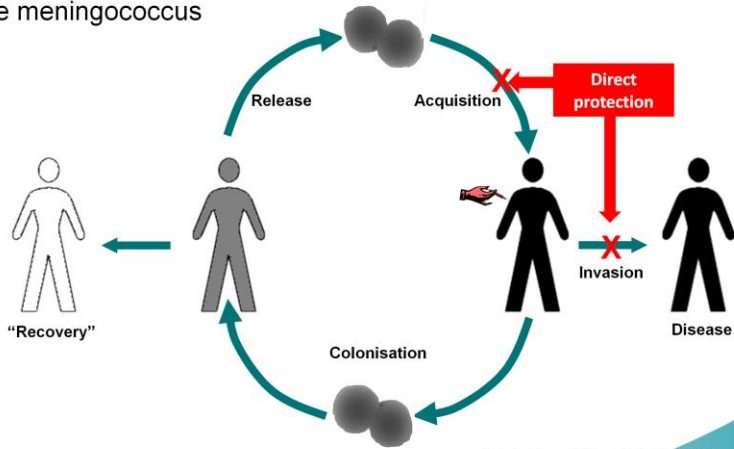
An effective vaccine would be expected to elicit this response in all (or at least the majority of) vaccinees, give life-long protection without repeated doses, stimulate a boostable response and offer protection against antigenically diverse strains

Vaccine safety is critical as they are given prophylactically to healthy individuals, who should remain healthy after vaccination.

- A parenterally administered vaccine must be sterile (although an orally administered vaccine may only need only be free of enteric pathogens).
- Vaccine manufacturers follow tightly regulated procedures (e.g. Good Manufacturing Practice; GMP) to ensure that vaccines are manufactured safely and consistently.
- Wherever possible they avoid the use of materials of human or animal origin.
- The acceptable safety of a vaccine may depend on the recipient. An adult choosing to receive a therapeutic anti-cancer vaccine may be prepared to accept a higher level of risk than a parent taking an infant for routine paediatric vaccination.

Direct Protection

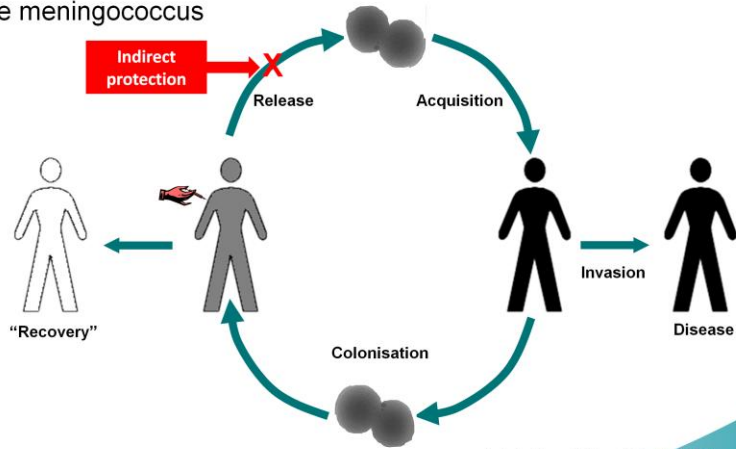
The transmission cycle of the meningococcus



Adapted from **Maiden, M.C.J. (2002)** Population structure of *N. meningitidis*. In *Emerging strategies in the fight against meningitis* (Eds. Ferreras, Criado & Vazquez).

Herd Immunity

The transmission cycle of the meningococcus



Adapted from **Maiden, M.C.J. (2002)** Population structure of *N. meningitidis*. In Emerging strategies in the fight against meningitis (Eds. Ferreras, Criado & Vazquez).

Herd Immunity

Endemic state:

$$R_0 = \frac{1}{S}$$

i.e. there is an inverse relationship between the basic reproduction number and the proportion of the population susceptible to the disease

$$S = 1 - q$$

i.e. immune + susceptible equals 1. The entire population can be divided into those who are immune and those who are susceptible to disease

Herd immunity:

$$q \geq 1 - \frac{1}{R_0}$$

i.e. if q is high enough (exceeds the critical threshold q_c) the disease will die out

R_0 , the basic reproduction number (i.e. the average number of other individuals each infected individual will infect in a population that has no immunity to the disease).

S , the proportion of the population (given as a decimal between 0 and 1) who are susceptible to the disease.

q , the herd immunity level

The term herd immunity refers to the effect of immunity within a population to reduce transmission of the infectious agent, thereby protecting those who are susceptible (i.e. not immune) to the disease. The endemic state reflects a balance between the transmissibility of the infectious agent and the level of immunity in the population. Herd immunity can be modelled mathematically and this slide shows this in a simplified form. q_c is the minimum proportion of the population that must be immunised at birth (or close to birth) in order for the infection to die out in the population.

Vaccine safety & efficacy are assessed in clinical trials



- Phase 1 trials
 - Primarily for safety but are often also used to assess immunogenicity
 - Usually small numbers of adults
- Phase 2 trials
 - Primarily for assessing immune response but also used to expand safety database
 - Typically includes all groups that are likely to use the vaccine
- Phase 3 trials
 - Protection studies, usually placebo controlled double blind trials
 - provide statistically conclusive data for licensure
 - Require good disease surveillance
 - case ascertainment
 - definition of endpoint
- EU Guidelines on clinical trials
 - Notes for guidance on clinical evaluation of new vaccines www.eudra.org/emea.html (CPMP/EWP/463/97)

Phase 1 trials entail close clinical monitoring of vaccinees. Data collected might include information on the following: local and systemic reactions, fever, diarrhoea and vomiting and headache etc.

Phase 2 trials provide an opportunity to investigate the effect of different dose regimes and formulations, examine laboratory assays for correlates/surrogates of protection, and for regulatory laboratories to evaluate the prospective vaccine and validate QC tests. All groups that are likely to use the vaccine include both sexes, a range of ages and different ethnic groups.

Phase 3 trials are designed to investigate directly the ability of a vaccine to offer protection against disease. This requires good disease surveillance. Efficacy is the measure of a vaccine to offer protection. Its assessment is scientifically rigorous (e.g. assessed by double blind, placebo controlled trial) and it is required for licensure. Effectiveness studies, sometimes termed phase 4 trials, measure the ability of the vaccine to achieve specific ends. They are scientifically less rigorous, study designs vary and they are not required for licensure. Effectiveness data can help to convince prospective users of the benefits of a vaccine.

Effectiveness studies are sometime referred to as Phase 4 studies.

Vaccine efficacy

- Vaccine efficacy is determined in Phase III trials
-blinded, placebo controlled

$$\text{Vaccine efficacy} = 1 - \frac{\text{Attack rate in vaccinated group}}{\text{Attack rate in unvaccinated group}}$$

- Usually expressed as a percentage

The herd effect

The herd effect is determined post vaccine introduction

$$\text{Herd effect} = 1 - \frac{\text{Attack rate unvaccinated post-introduction}}{\text{Attack rate unvaccinated pre-introduction}}$$

Vaccine formulations consist of three elements

- Antigen
 - To stimulate the immune response to the target disease
- Adjuvant
 - To enhance and modulate the immune response
- Excipients
 - Buffer, salts, saccharides and proteins to maintain the pH, osmolarity and stability of the vaccine
 - Preservative

The constituents of a vaccine formulation can be divided into three categories: the antigen(s), the adjuvant and other excipients.

Preservatives such as phenoxyethanol or the mercury containing Thiomersal may be added to multidose formulations to prevent growth of microbes once the vial has been punctured. Single dose vials or pre-filled syringes do not usually contain preservative.

Vaccine antigens

- Live attenuated organisms
 - Killed whole organisms
 - Purified component vaccines
 - Conjugates
 - DNA vaccines
- Complex, multiple antigens, ill defined.
- Individual or small number of well defined antigens.

The antigenic components of vaccines can be divided into four categories.

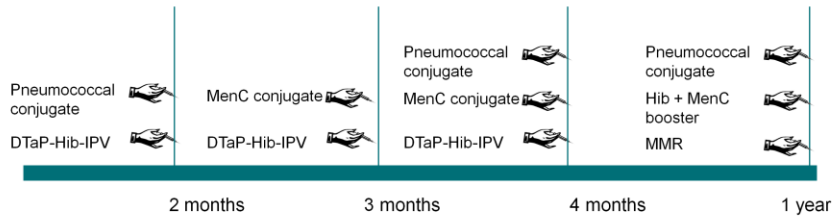
Live attenuated organisms. These contain mutations that affect the ability of the organism to thrive and/or cause disease in the host. Historically, the mutants were isolated by chemical mutagenesis or multiple passaging of the organism; more recently attenuated isolates have been rationally mutated using targeted molecular methods.

Killed organisms. Probably the simplest sort of vaccine to produce. The organism is grown and then killed either chemically (e.g. with phenol or formaldehyde) or by heating.

Component vaccines. The emergence of purified component vaccines has depended upon technological advances since the latter part of the 20th century. These have included advances in physical and chemical methods of separation as well as the development of recombinant DNA techniques, genome sequencing and bioinformatics (for the identification of prospective antigen genes in the genome).

DNA vaccines. The antigen gene is cloned in a vector so that it is expressed from a promoter sequence that is functional in the host. Once the DNA is injected, the host expresses the desired antigen and then mounts an immune response.

UK childhood immunisation programme



From three years four months onward:-

- Pre-primary school: DTaP-IPV booster, MMR booster
- Girls 12-13 years old: HPV
- During secondary education: DT-IPV

Paediatric combination vaccines

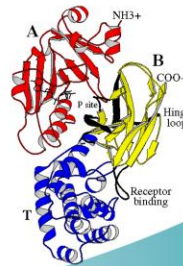
DTaP-Hib-IPV

- Tetanus and diphtheria toxoids
 - chemical inactivation of bacterial exotoxin
- Simple to produce
- Relatively pure
- Safe
- High protective efficacy
 - very immunogenic
 - appropriate immune response i.e. toxin neutralizing antibodies block activity

Tetanus spasm



Painting by Sir Charles Bell



Diphtheria toxin

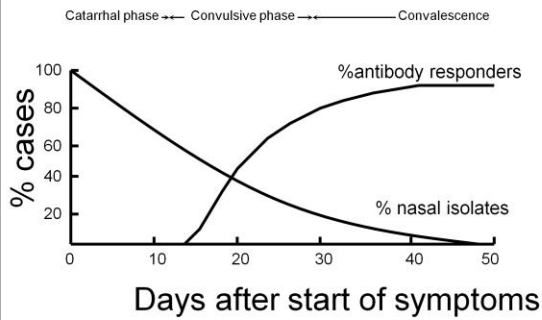
Tetanus toxin is a neurotoxin causing muscle spasm. It consists of light and heavy chains (MW 50kDa and 100kDa respectively). The light chain is a zinc endopeptidase that cleaves a membrane protein of synaptic vesicles (VAMP). The light chain stops the affected neurons from releasing the inhibitory neurotransmitters causing muscles to contract, so-called tetanus spasm. The toxoid used in vaccines is produced from filtered culture supernatant, which is treated with 40% formaldehyde at 37°C.

Diphtheria toxin like tetanus toxin is an exotoxin. It is a polypeptide with a MW of 58k and is secreted as a proenzyme which is cleaved into two fragments. Fragment B is responsible for attachment to and penetration of the host cell; Fragment A is the toxic moiety. It is an ADP-ribosylating enzyme that inhibits protein synthesis by blocking eukaryotic elongation factor 2 effectively blocking translation. Like tetanus toxoid, diphtheria toxoid is produced by formaldehyde treatment of culture supernatant.

More recently toxoids have been developed for the exotoxins including those produced by *Clostridium difficile* and *Pseudomonas aeruginosa* though these have yet to be licensed by the regulatory authorities.

Whooping Cough

DTaP-Hib-IPV



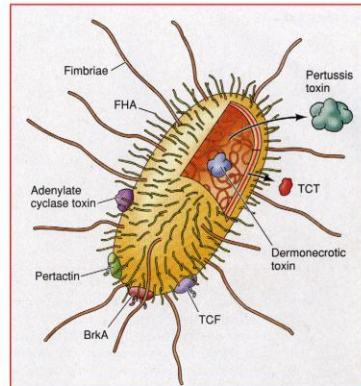
- Caused by *Bordetella pertussis* infecting ciliated epithelium and releasing toxin
- Condition identified by characteristic convulsive cough
- Recovery coincides with antibody production

Acceptability of whole cell pertussis vaccine

- Whole cell pertussis vaccine is effective
 - efficacy rates typically >90%
- It has been associated with a number of adverse reactions
 - anaphylaxis
 - prolonged crying
 - febrile seizures
 - acute encephalopathy (now known to be due to mutations within a sodium channel gene)
- Development of acellular (component) vaccine driven by poor acceptance of the whole cell vaccine

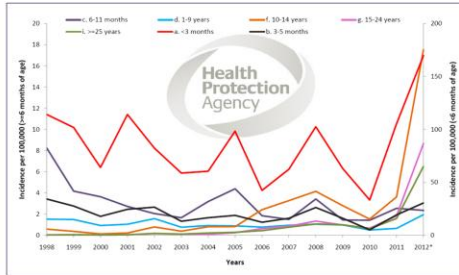
B. pertussis components associated with virulence

- Attachment to ciliated epithelium
 - filamentous haemagglutinin (FHA)
 - fimbriae
 - pertactin
- Adherence and complement resistance
 - BrkA
- Toxins
 - pertussis toxin (PT)
 - adenylate cyclase
 - tracheal cytotoxin
 - heat labile toxin
 - endotoxin
- Acellular vaccines
 - multicomponent (bi-,tri- and pentavalent formulations)
 - pertussis toxin, FHA, pertactin, fimbrial antigens 2 and 3
 - safe and efficacious (75-90%)



Current whooping cough problem

Incidence of laboratory-confirmed pertussis, by total case-patients and age group in England and Wales, 1998–2012*



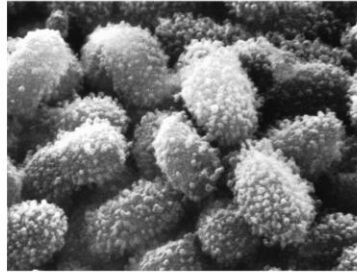
*2012 incidence extrapolated using data to week 25

- Ten deaths in newborns
- Pregnant women offered vaccination between 28 and 38 weeks
- Additional booster doses?
- Improved vaccine needed?

Haemophilus influenzae type b

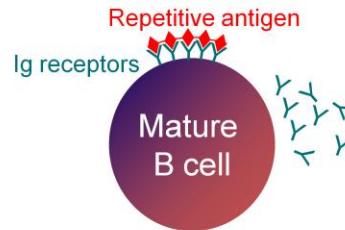
DTaP-**Hib**-IPV

- *H. influenzae* type b causes meningitis and septicaemia in the young.
- Bacterial surface covered by a polyribosyl-ribitol phosphate capsule.
- Polysaccharides are poorly immunogenic
- The Hib component is a conjugate vaccine



T cell independent antigens

- The Antigen
 - Usually large and linear
 - Not readily degraded
 - Highly repetitive determinant
- The Immune Response
 - Predominantly IgM
 - Poor memory effect
 - Low avidity antibody



T cell independent antigens like polysaccharides activate mature B cells, in the absence of antigen presentation, by cross-linking immunoglobulin receptors on the cell surface. The resulting immune response is not ideal for vaccination. It is typically characterised by poor immunological memory, low avidity antibodies (no affinity maturation) that are less likely to offer functional protection against disease, and in many cases repeated doses rather than boosting can lead to immunological hyporesponsiveness.

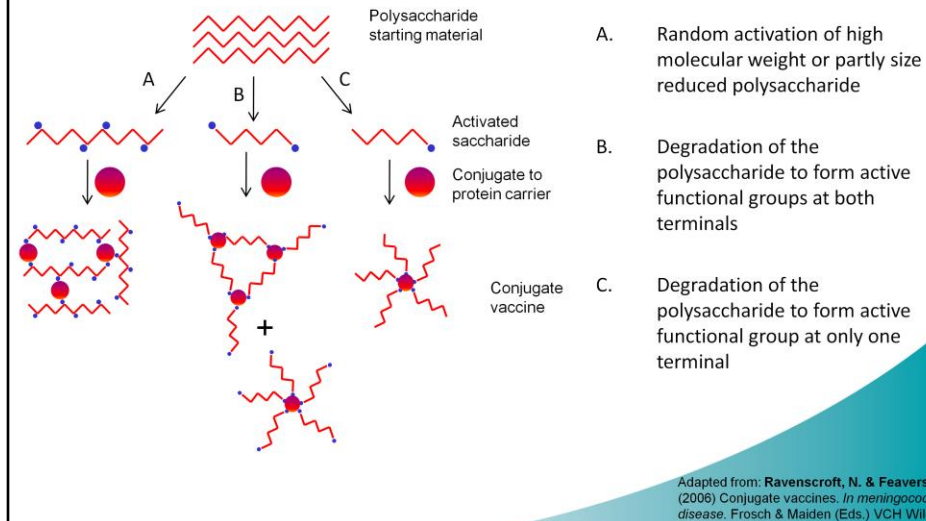
Conjugate Vaccines

Carbohydrate chemically linked to immunogenic protein

- Sophisticated technology
 - expensive
- Highly purified components
 - purified saccharide and carrier proteins such as tetanus toxoid, diphtheria toxoid or CRM₁₉₇
 - safe
 - simple for licensure and control
- Very effective when humoral immunity is required
 - long-lived, boostable immunity
 - reduce carriage i.e. offer herd immunity

Conjugate vaccines, in which the saccharide moiety is chemically linked to a protein carrier, overcome the drawbacks of plain polysaccharide vaccines by making them T cell dependent.

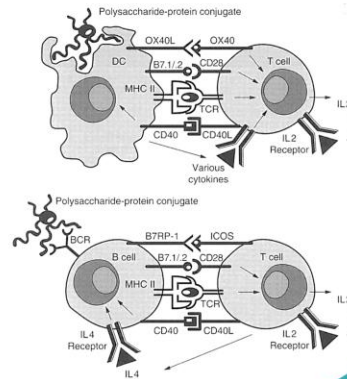
Preparation of Conjugate Vaccines



Various approaches have been taken to the preparation of conjugate vaccines. The molecular structure of the vaccine depends on the chemistry used for conjugation and the ratio of saccharide to conjugate.

T cell dependent antigens

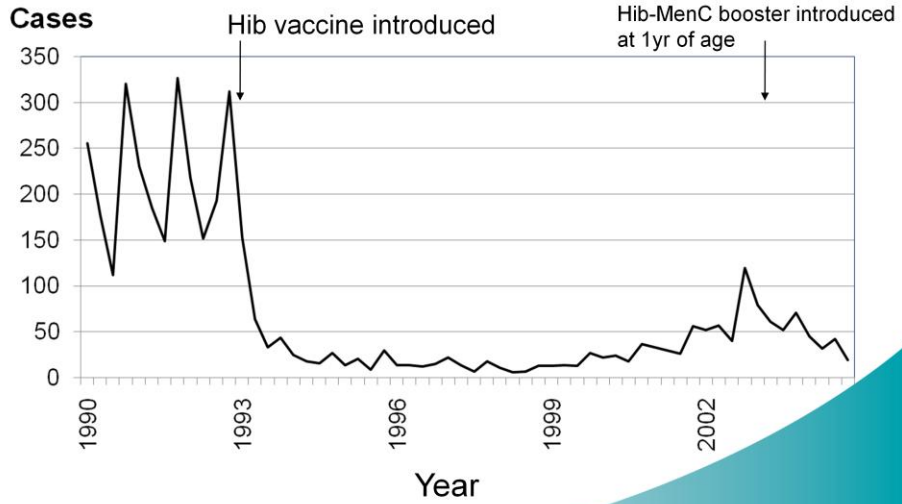
- Naive T cells primed by interaction with antigen presenting cells
 - Requires antigenic stimulation via MHCII-TCR pathway
- After priming T cells interact with B cells
 - Saccharide specific B cells take up conjugate and present the carrier peptides to T cells via MHCII
- Activated B cells differentiate into antibody secreting plasma cells and memory B cells



Adapted from Guttormsen *et al.* (1999)
Infect. Immun. 67: 6375-6384

Conjugate vaccines interact with the cells of the immune system, more like proteins than carbohydrates, to elicit T-cell dependent immunity.

Immunity to *Hib*



Paediatric combination vaccines



DTaP-Hib-IPV

- Examples include Pediacel[®] (Sanofi) and Infanrix[®] (GSK)
- Antigenes:
 - Tetanus toxoid
 - Diphtheria toxoid
 - Pertussis components:
 - pertussis toxoid,
 - filamentous haemagglutinin,
 - Pertactin
 - fimbriae types 2 and 3
 - Hib PRP-conjugate
 - Inactivated polio virus types 1,2 and 3
- Adjuvant: aluminium phosphate

Licensed conjugate vaccines



- Hib vaccine
 - Polyribosyl ribitol phosphate (PRP) conjugated to CRM₁₉₇ or tetanus toxoid
 - MenC+Hib booster - Menitorix
- Pneumococcal conjugates
 - Seven, 10- and 13-valent formulations
- MenC conjugates
 - α 2-9 linked polysialic acid conjugated to CRM₁₉₇ or tetanus toxoid
- Other conjugates
 - Meningococcal A, C, W, Y conjugates
 - Novartis CRM conjugate Menveo™
 - GSK TT conjugate Nimenrix™

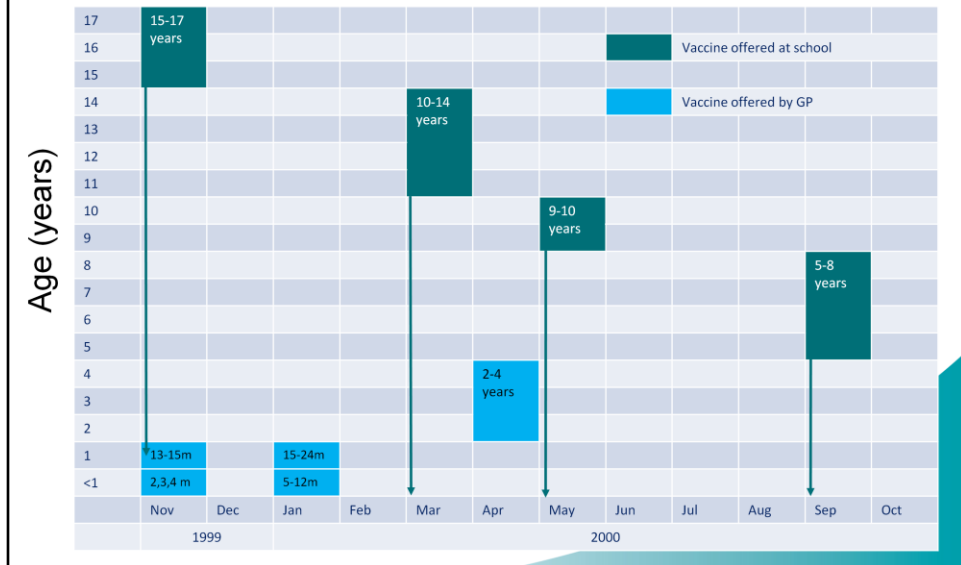
Hib vaccines are usually offered in combination with other paediatric components – DTaP and polio.

There are over 90 serotypes of pneumococci, many of which cause disease. The first conjugate to be licensed by Wyeth Vaccines (now part of Pfizer) offered protection against 7 serotypes (4, 6B, 9V, 14, 18C, 19F, 23F). This vaccine is known as Prevenar. This year GSK has licensed a 10-valent pneumococcal conjugate (serotypes 4, 6B, 9V, 14, 18C, 19F, 23F plus 1, 5, 7F) in which the carrier protein is an antigen, known as protein D, from the surface of non-typeable *Haemophilus influenzae*. This vaccine is known as Synflorix. Wyeth currently has a licence application under consideration at the FDA and the EMEA for a 13-valent version of Prevenar (4, 6B, 9V, 14, 18C, 19F, 23F plus 1, 3, 5, 6A, 7F, 19A).

There are four versions of MenC conjugates licensed in Europe: Meningitec (Pfizer), Menjugate (Novartis), NeisVac (Baxter) and Menitorix (bivalent Hib/MenC booster, GSK).

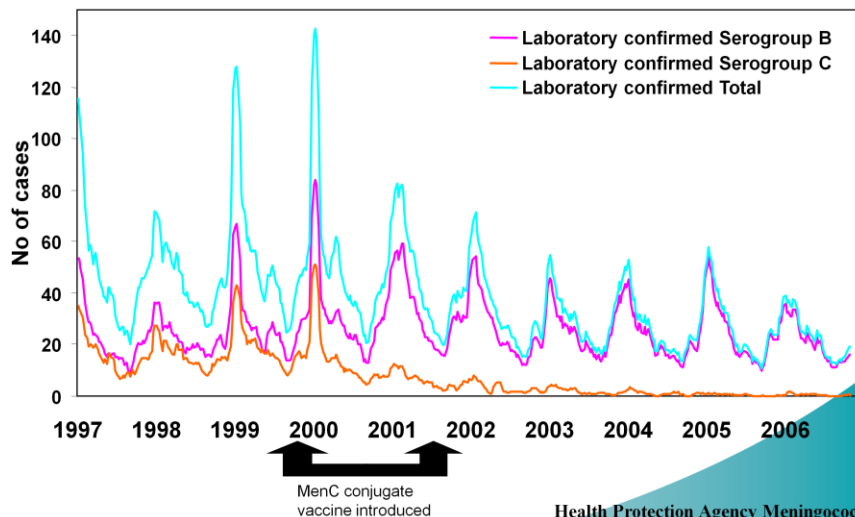
The conjugate vaccine approach has arguably been one of the most successful developments of the late 20th century and many other conjugate vaccines are under development.

Mass vaccination programme with MenC conjugate in the UK



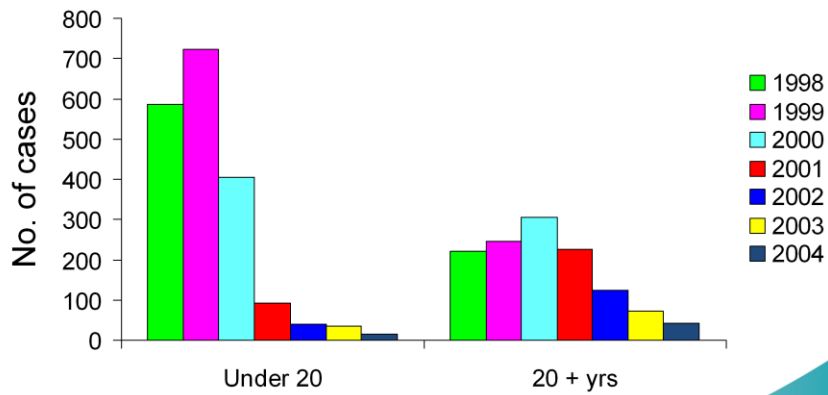
This shows how the vaccine was rolled out in the UK as increasing numbers of doses became available. The programme started with the groups most at risk of infection and ended with those least at risk. For those between the ages of 5 and 18 the vaccine was administered at school or college. The preschool children were vaccinated at the local surgery.

Laboratory Confirmed Cases of Meningococcal Disease in England & Wales



This figure shows the 5 week moving average of the number of cases of meningococcal disease occurring in England and Wales between 1997 and 2007. Almost immediately after the roll-out of the MenC conjugate vaccine the number of cases of MenC disease, shown by the red line, started to decline. Since 2005 there has been almost no disease in the UK. Since the introduction of the vaccine almost all disease in the UK has been caused by serogroup B meningococci for which there is currently no vaccine.

Serogroup C meningococcal infections



Ramsay, M., CDSC, unpublished data

The number of cases of serogroup C meningococcal disease was reduced dramatically in both the vaccinated and unvaccinated age groups. This suggested that the vaccine offered herd immunity.

MenC efficacy, effectiveness and herd immunity



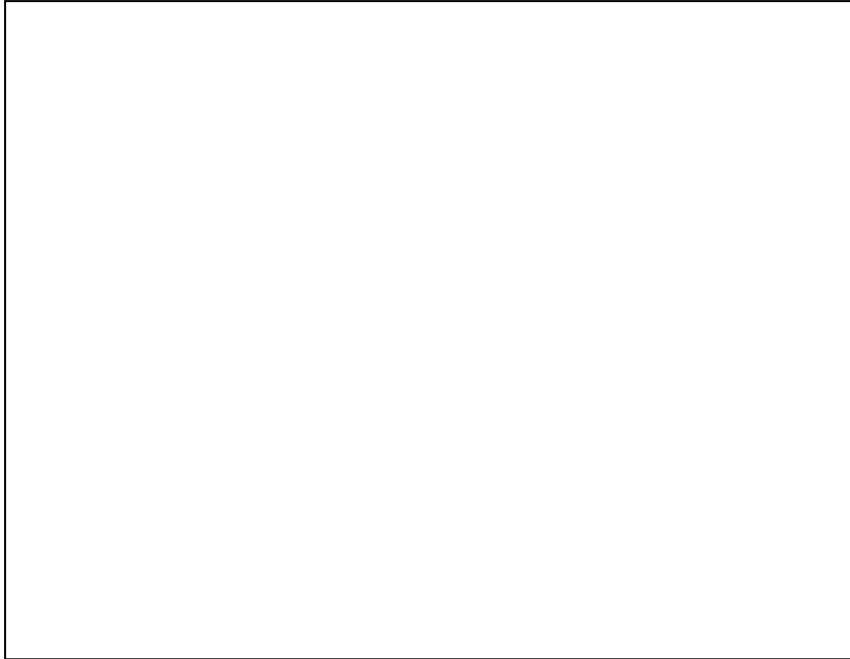
Overall efficacy, effectiveness and herd immunity July
2001-June 2002: < 18 yrs olds

Efficacy during 2001/2	1- $\frac{\text{ARV}_{2001-2}}{\text{ARUn}_{2001-2}}$	93.5%
Effectiveness in unvacc (herd immunity)	1- $\frac{\text{ARUn}_{2001-2}}{\text{ARUn}_{1998-99}}$	66.8%

ARV = attack rate in vaccinated

ARUn = attack rate in unvaccinated

Efficacy, effectiveness and herd immunity were assessed for the epidemiological year 2001-2002.



Geometric mean titer (GMT) of serum bactericidal antibody (SBA) against group C meningococci. Shown are current levels (2009) compared with the period shortly after vaccine introduction (2000 to 2004). Meningococcal carriage is at its peak in young adult, so it's important that immunity remains high in this age group if herd immunity is to be maintained.

Pneumococcal disease



- *Streptococcus pneumoniae* is significant cause of meningitis and septicaemia worldwide
- It is also an important cause of mucosal infections, e.g. pneumonia and otitis media
- More than 90 serotypes determined by capsular polysaccharide
 - Antibiotic resistance associated with some serotypes
- Vaccines
 - Pneumovax II™, 23-valent plain (unconjugated) polysaccharide vaccine
 - Prevenar 7™, Prevenar 13™ and Synflorix™ conjugate vaccines

Pneumococcal conjugate vaccine efficacy: invasive disease and pneumonia



Double-blind study at Northern California Kaiser Permanente medical centres

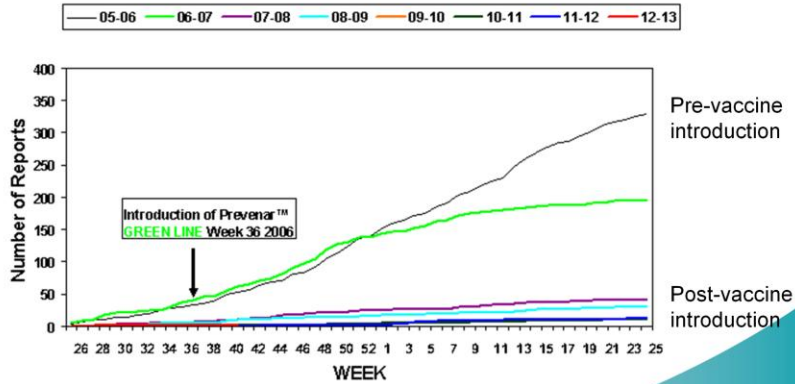
Analysis for serotypes in vaccine	Cases Control:Vaccine	Efficacy (95% CI)	P
Fully vaccinated per protocol	39:1	97.4 (82.7-99.9)	<0.001
Intent to treat	49:3	93.9 79.6-98.5)	<0.001
Partially vaccinated	7:1	85.7 (0-100)	0.05
All cases regardless of serotype	55:6	89.1 (73.7-95.8)	<0.001

- Cases of pneumonia significantly reduced where there was a positive radiograph from 10.1 to 8.3 per 1000 person-years
- Estimated efficacy 17.7% (95% CI: 4.8 to 28.9) against pneumonia
- Reduction in cases of otitis media by 7-9%

Data from **Black et al.** (2000) *Pediatr. Infect. Dis. J.* 19: 187-195

Pneumococcal disease among the young in England and Wales

Cumulative weekly number of reports of Invasive Pneumococcal Disease due to any of the seven serotypes in Prevenar™ : Children aged < 2 Years in England and Wales by Epidemiological Year: July-June (2005 - to date)

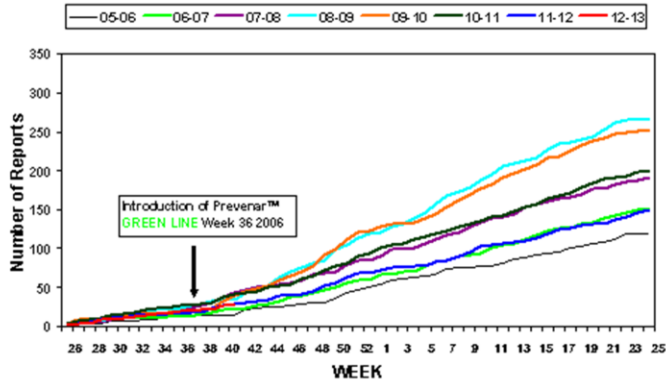


Source: Health Protection Agency, Centre for Infections

Cumulative curves of the cases of disease occurring across the year provide a convenient way of looking at the impact of a vaccination programme. The introduction of the 7-valent conjugate in the UK caused a dramatic reduction in invasive pneumococcal disease caused by the serotypes included in the vaccine. The green line represents the year in which the vaccine was introduced, the blue and purple lines the subsequent two years.

Pneumococcal disease among the young in England and Wales

Cumulative weekly number of reports of Invasive Pneumococcal Disease due to any of the seven serotypes **NOT IN** Prevenar™ : Children aged < 2 Years in England and Wales by Epidemiological Year: July-June (2005 – to date)



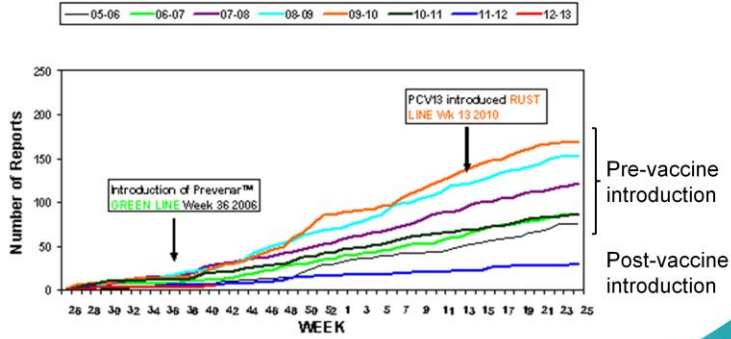
Source: Health Protection Agency, Centre for Infections

As expected the incidence of non-vaccine serotypes did not change immediately following the introduction of the 7-valent vaccine (green line). However, there was subsequently been a notable increase in invasive pneumococcal disease caused by the non-vaccine serotypes. The introduction of 13-valent formulations appears to address this problem (dark blue and red lines).

Pneumococcal disease after introduction of Prevenar 13[®]



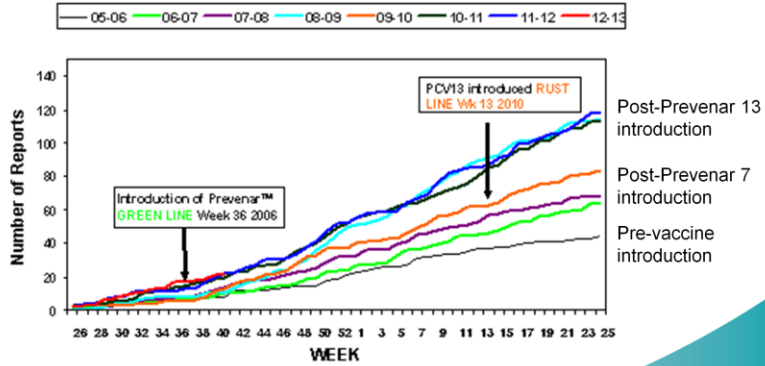
Cumulative weekly number of reports of Invasive Pneumococcal Disease due to any of the six serotypes in Prevenar13[™] but not in PCV7 : Children aged < 2 Years in England and Wales by Epidemiological Year: July-June (2007- To Date)



Pneumococcal disease after introduction of Prevenar 13[®]

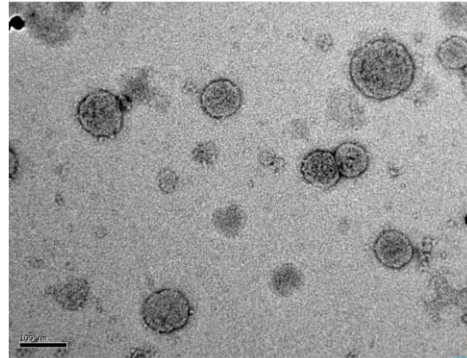


Cumulative weekly number of reports of Invasive Pneumococcal Disease due to any of the serotypes **NOT IN** Prevenar13[™] : Children aged < 2 Years in England and Wales by Epidemiological Year: July-June (2005- To Date)



Meningococcal Outer Membrane Vesicle Vaccines

- OMVs are released spontaneously by meningococci *in vivo* and in culture

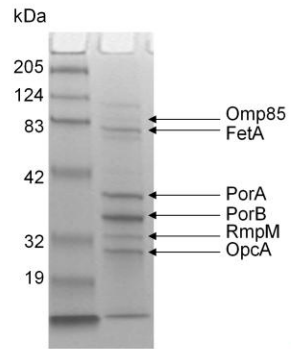


Picture by Anwen Bullen and Roland Fleck

The meningococcus is one of a small number of Gram –ve species that naturally bleb off outer vesicles of outer membrane. Just like the outer membrane they consist of lipopolysaccharide (LPS) and proteins. Vaccine is made by extracting the OMVs with detergent to reduce the LPS content and thereby make them less reactogenic. These vaccines are more complex than other purified component vaccines. Even with very careful manufacture the antigen profile and the LPS content can vary from batch to batch.

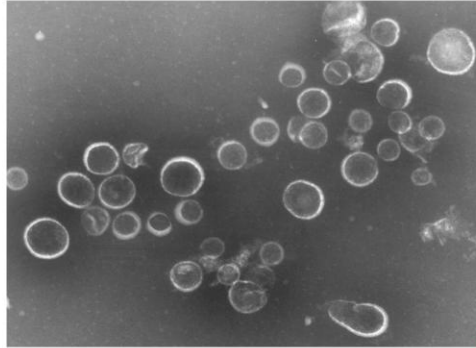
Meningococcal Outer Membrane Vesicle Vaccines

- OMVs are released spontaneously by meningococci *in vivo* and in culture
- They contain all the protein antigens usually associated with the OM







Meningococcal Outer Membrane Vesicle Vaccines

- OMVs are released spontaneously by meningococci *in vivo* and in culture
- They contain all the protein antigens usually associated with the OM
- Vaccines are produced by detergent extraction to reduce endotoxin content
- Hyper-producing mutants have been isolated



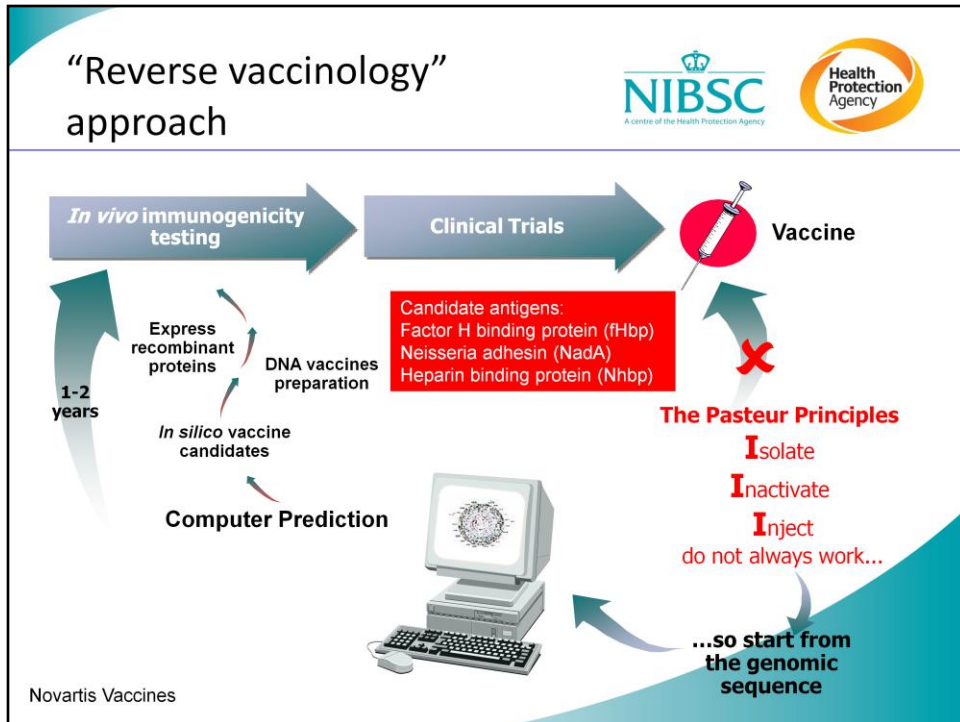
OMV size range 50-200 nm

Clinical Trials with OMV vaccines

	<u>Year</u>	<u>Age group</u>	<u>Vaccine</u>	<u>Estimated efficacy</u>
 Cuba	1987-89	10 - 14 years	4:P1.15+C	83%
 Brazil	1989-91	3 months - 6 years	4:P1.15+C	47-74%
 Norway	1989-91	11 - 16 years	15:P1.16	57%
 Chile	1987-89	1 - 21 years	15:P1.3+C	51%

Vaccines only offer good protection against the homologous strain

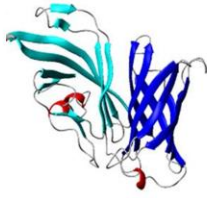
OMV vaccines have been evaluated in a number of efficacy studies. In general, protection is variable and strain specific, especially in the very young who are most at risk of infection. The predominant protective antibody response is directed at the PorA protein antigen i.e. PorA is said to be immunodominant in this vaccine. The vaccine is strain specific because PorA is antigenically variable; its amino acid sequence is different in different isolates.



In the era of genome sequence data, an alternative to the classical approach to identifying vaccine candidates is first to identify potential candidate antigens in the computer. The candidates are then over expressed in a suitable expression system. Novartis has used this method to identify three new meningococcal antigens. Sequence analysis indicates that these proteins are less variable than PorA and it is hoped that a vaccine based on these antigens would be broadly cross-protective against diverse meningococcal strains.

New “MenB” vaccine targets non-capsular antigens

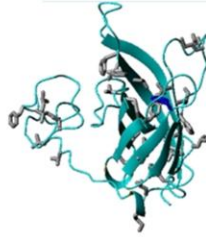
NIBSC
A centre of the Health Protection Agency



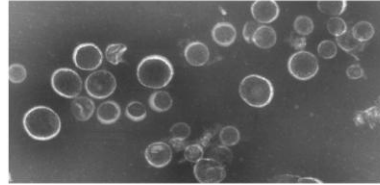
Factor H binding protein



NadA



Heparin binding antigen



OMVs from NZ outbreak strain (PorA immunodominant antigen)

- Bexsero™ contains OMVs from strain NZ98/254 enhanced with three antigens found by scanning genome
- Clinical trials show it to be safe and immunogenic
- License application with the European Medicines Agency
- Level of cross-protection to be confirmed

New MenB vaccine could be available in 2013. It is described as a four component vaccine and is in effect a modification of the OMV vaccine used in New Zealand that is enhanced by the addition of antigens discovered using reverse vaccinology.

Vaccination against tuberculosis (BCG)

- Attenuated strain of *Mycobacterium bovis*.
 - Serial passage, 231 times over 13 years (1908-1921)
 - Phenotypic changes: rough/dry to moist/smooth
 - Genotypic changes: loss of RD1 region encoding 9 proteins



Albert Calmette (1863-1933)



Camille Guérin (1872-1961)

Does BCG work?

- Cannot be answered definitively
 - Vaccination programmes instituted at the same time as social, economic and public health improvements
 - Generally accepted that it prevents severe childhood TB and leprosy
- Variation in field trials of BCG
 - Trial methodology
 - Vaccine variation (strain, dose, potency)
 - Regional differences in TB strains
- New candidate vaccines are in the research pipeline
 - recombinant modified vaccinia virus expressing antigen 85A

Evidence for the effectiveness of BCG vaccine is equivocal. As a result, there are a number of candidate vaccines in the R&D pipeline. Arguably the most advanced of these, in terms of clinical development, is the recombinant modified vaccinia virus Ankara (smallpox vaccine) expressing a major secreted antigen from Mycobacterium tuberculosis, antigen 85A.

Typhoid Vaccines

- Vivotif[®] live attenuated vaccine based on strain Ty21a
 - *galE* mutant of *S. typhi* Ty2
 - isolated by NTG mutagenesis
 - formulated in enteric-coated capsules
- Vi polysaccharide (TyphimVi[®] and Typherix[®])
 - Offered to those travelling to typhoid endemic areas
 - Only suitable for >2 year olds
 - Conjugates in development



Typhoid, or enteric fever, is caused by the bacterium *Salmonella enterica* serovar typhi. It is transmitted by the ingestion of faecally contaminated food or water. The bacteria invade the intestinal wall and are taken up by macrophages. *S. typhi* is adapted to survive within the macrophage, which renders them resistant to damage by the immune response. In this form it is then spread throughout the body via the lymphatics. Typhoid fever is characterised by a sustained fever, profuse sweating, gastroenteritis, and non-bloody diarrhoea. It is a major global health problem causing an estimated 16-32 million cases annually and up to half a million deaths in endemic regions.

The live attenuated typhoid vaccine was developed using “old” technology, i.e. chemical mutagenesis. It is taken orally which ensures a good immune response in the gut. The organisms are lyophilised in enteric coated capsules allowing them to pass safely through the low pH environment in the stomach. The capsules are acid resistant but dissolve readily at neutral pH.

Killed Whole Cell Cholera Vaccine

- Killed whole cell parenteral vaccine
 - poor efficacy
 - short-lived protective response
 - strain specific
- Killed whole cell oral vaccine
 - good efficacy in cholera endemic area (Vietnam trials)
 - oral delivery
 - safe
 - >85% show >4-fold rise in vibriocidal antibodies (<3% in controls)
 - protective efficacy 66% after two doses
 - WHO mediated technology transfer
- Dukoral™
 - killed whole cell + CtxB oral vaccine
 - drink formulation (3 doses at weekly intervals, booster every 2 years)
 - may also protect against ETEC



The first cholera vaccine, developed in the 1920s, was a killed organism preparation, which was highly reactogenic and had questionable efficacy. It was largely discredited in a number of reports during the latter part of the 20th century and the WHO recommendation for its use was withdrawn in the early 1990s.

Recently, an orally administered version of the vaccine has proved to be safe and more efficacious in studies in the Far East. This vaccine has been produced in Vietnam following a technology transfer agreement with a Swedish company, SBL. The version of the vaccine produced in Sweden also contains recombinant B subunit of the enterotoxin. As this is immunologically cross-reactive with enterotoxin produced by some strains of *E. coli* (ETEC), there is some evidence to suggest that this vaccine also offers protection against diarrhoea cause by ETEC.

Adjuvants

Adjuvants are a key element of effective vaccines. They potentiate the immune response (humoral, cellular or both).

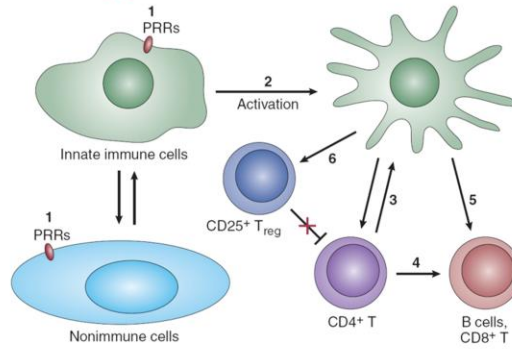
- Delivery systems, usually a depot of antigen which is slowly released
 - mineral salts
 - surface active agents
 - synthetic microparticles
 - oil-water emulsions
 - liposomes
- Immune potentiators
 - Toxins and lipids
 - Nucleic acids
 - Peptidoglycan
 - Carbohydrates
 - Peptides
 - Cytokines and hormones

Adjuvants are not themselves the functional component of vaccines in the sense that the antigens are but they serve to potentiate and direct the immune response. They can serve one or a combination of roles. They might be used simply to enhance/strengthen the immune response, to determine whether the humoral or CMI arms of the immune system are stimulated, to direct the Th cell response, or to favour antibody subclasses.

Adjuvants broadly fall into two groups: delivery systems and immune potentiators. The former usually create a depot of antigen that can be released over a period to maximise the immune response. The latter specifically stimulate the immune system to obtain the desired response.

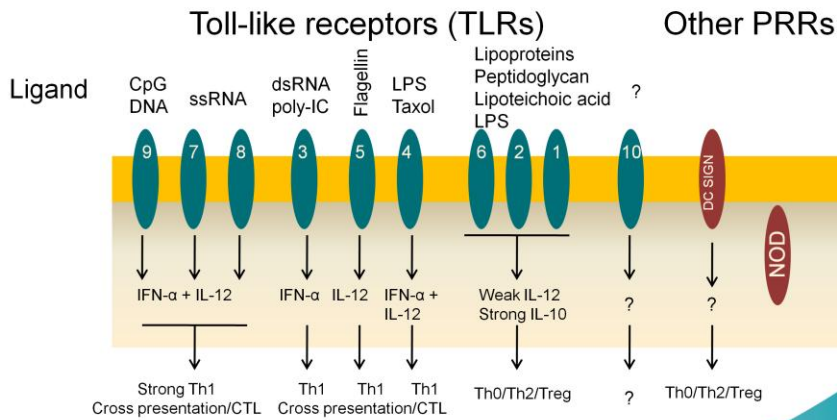
Pattern recognition receptors (PRRs) bind microbial PAMPs and stimulate the immune response

PAMP = Pathogen Associated Molecular Pattern



The immunostimulatory adjuvant components often contain PAMPs. These are recognised by receptors on cells of the innate immune system ultimately causing them to produce cytokines that influence the behaviour of other cells in the immune system. Adjuvants function primarily before an acquired immune response has been induced to influence the nature and potency of that response.

Pattern recognition receptors



This slide provides some examples of PRRs on innate immune cells. Ligands that might typically be associated with viruses (e.g. nucleic acids) stimulate interferon and IL-12 production which in turn drive a Th1/cytotoxic lymphocyte response. This would be appropriate for the elimination of a viral infection. Conversely, bacterial PAMPs such as LPS, lipoproteins and peptidoglycan stimulate IL-10 which drives a Th2/humoral type response, which is more appropriate for the elimination of bacterial infections.

Examples of adjuvants licensed for use in humans

Adjuvant type	Licensed Examples	Description	Vaccines
Mineral salts	Aluminium and Calcium salts	Long established adjuvant widely used in current vaccines	DTP, conjugates etc.
Emulsions and surfactant-based formulations	MF59	Microfluidized detergent-stabilized oil-in-water emulsion	Influenza vaccine
Particulate delivery systems	Virosomes	Unilamellar liposomal vehicles	Flu and HepA
	VLPs	Virus subunits	HPV vaccine
Microbial derivatives	MPL	Monophosphoryl lipid A	HPV vaccine

Vaccinating the immunocompromised: a risk benefit analysis



- Need to protect the vulnerable patient
- Public health perspective (herd immunity)
- Protect the patient by immunising close contacts
- Live vaccines need particular consideration
- Decision on whether to vaccinate depends on the nature of the immunodeficiency and the vaccine