CONCISE REPORT

Pneumococcal polysaccharide vaccination in rheumatoid arthritis patients receiving tocilizumab therapy

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ABSTRACT

Objectives We assessed the impact of tocilizumab (TCZ), a humanised monoclonal anti-interleukin-6 receptor antibody, on antibody response following administration of the 23-valent pneumococcal polysaccharide vaccine (PPV23).

Methods A total of 190 patients with rheumatoid arthritis (RA) received PPV23. Patients were classified into TCZ (n=50), TCZ + methotrexate (MTX) (n=54), MTX (n=62) and RA control (n=24) groups. We measured serotype-specific IgG concentrations of pneumococcal serotypes 6B and 23F using ELISA and functional antibody activity using a multiplexed opsonophagocytic killing assay, reported as the opsonisation indices (OIs), before and 4–6 weeks after vaccination. Positive antibody response was defined as a 2-fold or more increase in the IgG concentration or as a ≥10-fold or more increase in the OI.

Results IgG concentrations and OIs were significantly increased in all treatment groups in response to vaccination. The TCZ group antibody response rates were comparable with those of the RA control group for each serotype. MTX had a negative impact on vaccine efficacy. Multivariate logistic analysis confirmed that TCZ is not associated with an inadequate antibody response to either serotype. No severe adverse effect was observed in any treatment group.

Conclusions TCZ does not impair PPV23 immunogenicity in RA patients, whereas antibody responses may be reduced when TCZ is used as a combination therapy with MTX.

INTRODUCTION

Streptococcus pneumoniae (pneumococcus) infection is responsible for substantial mortality and morbidity among adults aged ≥65 years or those with underlying chronic or immunosuppressive conditions. The CDC Advisory Committee on Immunization Practice has recommended the use of the 23-valent pneumococcal polysaccharide vaccine (PPV23) for prevention of invasive pneumococcal disease in at-risk populations.1 Patients with rheumatoid arthritis (RA) are at an increased risk of contracting infectious diseases because of immunological changes that are intrinsic to RA and that result from immunosuppressive agents, and thus it is likely that pneumococcal vaccination can benefit this patient population.

Tocilizumab (TCZ), a humanised monoclonal antibody against the interleukin-6 (IL-6) receptor, is effective and generally well tolerated when administered either as monotherapy or in combination with methotrexate (MTX) in patients with moderate to severe RA. IL-6 was originally identified as a factor essential for B cell differentiation into antibody producing plasma cells,2 and IL-6-deficient mice had reduced antigen-specific IgG following immunisation with a T-cell-dependent antigen.3 PPV23 induces serotype-specific IgG in a T-cell-independent polysaccharide antigen pathway, which can enhance pneumococcal opsonisation, phagocytosis and killing by phagocytic cells.4 PPV23 immunogenicity is often impaired in certain groups of immunocompromised patients,5 but evidence of PPV23 efficacy and safety is lacking in RA patients receiving TCZ.

The objective of the present study was to evaluate the influence of TCZ therapy on antibody response to PPV23 in RA patients. We determined the serum concentrations of serotype-specific IgG using ELISAs and the functional antibody activity using multiplexed opsonophagocytic killing assays (OPAs) in RA patients being treated with TCZ, MTX or TCZ and MTX, and in control RA patients who received neither drug.

METHODS

Patients

RA patients who were receiving TCZ therapy (at least the first dose of an intravenous infusion of 8 mg/kg every 4 weeks) and/or MTX (4–18 mg per week) for ≥12 weeks at our rheumatology outpatient clinics were invited to participate in this open-label study. RA patients who had been treated with buparlisib or salazosulfapyridine were also included as RA controls. All participants fulfilled the 1987 American College of Rheumatology criteria for RA diagnosis. Exclusion criteria were current prednisolone use (≥10 mg/day), current use of immunosuppressive anti-rheumatic drugs other than MTX (such as tacrolimus, cyclosporine, leflunomide, cyclophosphamide and azathioprine), a recent history (within 6 months) of pneumococcal infection and a history of pneumococcal vaccination. Patients who had changed treatments during the follow-up period or those who had received biological agents other than TCZ were also excluded from this study.

Vaccine

We used commercially available PPV23 (Pneumovax NP Merck Sharp & Dohme Corp., Tokyo, Japan) containing 25 µg each of 23 capsular polysaccharide

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types. From October 2011 to March 2012, each patient received a single dose of vaccine (0.5 ml) subcutaneously in the upper arm. For RA patients receiving TCZ, the vaccination was performed on the same day as the TCZ infusion.

**ELISAs for serotype-specific IgG and multiplexed OPAs**
Sera were collected immediately before and 4–6 weeks after vaccination and stored at −30°C until tested. To measure serotype-specific IgG concentrations and functional antibody activity against pneumococcus serotypes 6B and 23F, we performed ELISAs and multiplexed OPAs, respectively. For detailed protocols, see online supplementary text.

**Antibody response**
Fold increases relative to pre-vaccination values (post-vaccination value to pre-vaccination value ratios) were determined. Positive antibody response was defined as a 2-fold or more increase in IgG concentrations or as a 10-fold or more increase in opsonisation indices (OIs).3

**Monitoring adverse effects**
Adverse events that occurred during a follow-up period of 4–6 weeks after vaccination were recorded. Systemic adverse effects included fever, headache, myalgia, asthenia and fatigue. Local adverse events included pain/tenderness, swelling/induration and erythema at the injection sites.

**Statistical analysis**
To access the PPV23 immunogenicity in patients in each treatment group, IgG concentrations and OIs before and after vaccination were transformed into logarithmic values. IgG geometric mean concentrations (GMCs) and geometric mean OIs (GM-OIs) were calculated as the exponential of an arithmetic mean of log-transformed values. For details regarding statistical analysis, see online supplementary text.

**RESULTS**

**Clinical and demographic characteristics**
A total of 190 RA patients were divided into four groups according to their ongoing anti-RA therapy. There was one group of 50 patients treated with TCZ as monotherapy (TCZ group), 62 patients treated with MTX alone (MTX group), 54 patients who received a combination therapy consisting of TCZ and MTX (TCZ+MTX group) and 24 patients who did not receive either drug (RA control group). Prior to participating in this study, no patients had received a pneumococcal vaccination. Patients’ clinical and demographic characteristics are shown in table 1.

**Serotype-specific IgG concentrations**
After vaccination, serotype-specific IgG GMCs to pneumococcal serotypes 6B and 23F in all four groups were increased significantly (p < 0.0005; table 2). For serotype 6B, a significantly higher post-GMC was obtained in the TCZ group compared with that in the TCZ+MTX group (p = 0.004). The TCZ group also showed a significantly greater fold increase than did the TCZ+MTX group (p = 0.036). For serotype 23F, the TCZ group also showed a significantly higher post-GMC than did the MTX group (p = 0.027). Increases were twofold or more in all treatment groups, and there were no statistically significant differences.

**Opsonophagocytic killing assays**
After vaccination, GM-OIs for the 6B and the 23F serotypes were increased significantly in all four groups (p < 0.0005; table 2). For serotype 6B, the post-vaccination GM-OI was significantly higher in the TCZ group compared with that in the MTX group (p = 0.001). The TCZ group also showed a significantly higher post-vaccination GM-OI for serotype 23F compared with the MTX group (p = 0.001) or with the TCZ+MTX group (p = 0.042). For either serotype, there were no significant differences in fold increases among the four treatment groups.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Clinical and demographic characteristics of RA patients prior to pneumococcal vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTX group (n=62)</td>
<td>TCZ+MTX group (n=54)</td>
</tr>
<tr>
<td>Male/female</td>
<td>Male/female</td>
</tr>
<tr>
<td>Male, mean (95% CI) (years)</td>
<td>68.3 (66.6 to 70.1)</td>
</tr>
<tr>
<td>RA duration, mean (95% CI) (years)</td>
<td>10.0 (7.8 to 12.1)</td>
</tr>
<tr>
<td>MTX dose, median (IQR) (mg/week)</td>
<td>8 (6 to 8)</td>
</tr>
<tr>
<td>MTX duration, median (IQR) (months)</td>
<td>48 (14.3 to 86.3)</td>
</tr>
<tr>
<td>TCZ duration, median (IQR) (weeks)</td>
<td>36 (16 to 95)</td>
</tr>
<tr>
<td>Use of prednisolone, number of patients (%)</td>
<td>17 (27.4)</td>
</tr>
<tr>
<td>Prednisolone dose, median (IQR) (mg/day)</td>
<td>0 (0 to 2)</td>
</tr>
<tr>
<td>Positive RF, number of patients (%)</td>
<td>35 (56.5)</td>
</tr>
<tr>
<td>Positive anti-CCP Abs, number of patients (%)</td>
<td>44 (71.0)</td>
</tr>
<tr>
<td>Lymphocytes, mean (95% CI) (/μL)</td>
<td>1374 (1230 to 1517)</td>
</tr>
<tr>
<td>Serum IgG, mean (95% CI) (mg/dl)</td>
<td>1286 (1194 to 1377)</td>
</tr>
</tbody>
</table>

Data were obtained immediately before pneumococcal vaccination. p Values between treatment groups were determined using the Mann–Whitney U test, ANOVA (analysis of variance) with a Tukey’s HSD (honesty significant difference) post hoc test, the Kruskal–Wallis test with a Scheffe post hoc test, the chi² test or Fisher’s exact probability test. -anti-CCP Abs, anti-cyclic citrullinated peptide antibodies; M, MTX group; MTX, methotrexate; NS, not significant; RA, rheumatoid arthritis; RF, rheumatoid factor; T, TCZ group; T/M, TCZ+MTX group; C, RA control; TCZ, tocilizumab.

There was a moderate correlation between IgG concentrations and OIs for the 6B and the 23F serotypes (serotype 6B: r=0.623, p<0.0005; serotype 23F: r=0.601, p<0.0005).

### Antibody response rates (percentages of patients with positive antibody response)

The TCZ group antibody response rates were comparable with those of the RA control group for serotypes 6B and 23F (figure 1).

For the IgG concentration specific to serotype 6B, the antibody response rate was significantly higher in the TCZ group (56%) compared with that in the MTX group (37%) and the TCZ+MTX group (24%, p=0.046 and p=0.0009, respectively; figure 1A). For serotype 23F, there was no significant difference in the antibody response rate among the four treatment groups (Control: 67%; MTX: 57%; TCZ+MTX: 56%; TCZ: 72%). The percentage of patients with positive antibody response for both strains were significantly greater in the TCZ group (46%) compared with those of the RA control group for serotypes 6B and 23F (for serotype 6B: OR 0.45, 95% CI 0.25 to 0.82, p=0.009; for serotype 23F: OR 0.56, 95% CI 0.31 to 0.82, p=0.007) and OIs for serotype 23F (OR 0.54, 95% CI 0.29 to 0.99, p=0.046).

### Vaccination safety

Two patients in the TCZ+MTX group had a fever. Local adverse events were observed in 12 patients (2 in the MTX group, 7 in the TCZ+MTX group and 3 in the TCZ group). All adverse effects were mild.

### DISCUSSION

Following immunisation with PPV23, IgG concentrations and OIs for the 6B and the 23F serotypes were significantly increased in all treatment groups. Antibody response rates in the TCZ group were comparable with those of the RA control group for each serotype. Ongoing use of MTX is likely to have affected the antibody response to PPV23.

Results of the present study indicate that TCZ does not diminish T-cell-independent antibody production after PPV23 immunisation. In addition, we recently reported that TCZ+MTX group and 3 in the TCZ group). All adverse effects were mild.

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In the present study, no patients were receiving high doses of prednisolone or antihistaminic agents with immunosuppressive effects other than MTX. In addition, there were no differences in the prednisolone dose among the four treatment groups, and the median dose of prednisolone was zero among all groups. The number of prednisolone users was significantly lower in the RA control group; however, there were no significant differences or trends in antibody response to each serotype compared with the other three groups. We can, therefore, say that the influence of such agents on PPV23-induced antibody response was minimal in the present study.

One limitation of this study is the relatively small number of patients in each group and the RA control group in particular. Since most RA patients had already received one or more immunosuppressive antirheumatic drugs, as recommended by the current therapeutic guidelines, it was difficult to recruit a sufficient number of patients who had never received such drugs. Another limitation is that we determined antibody response to only two pneumococcal serotypes. We chose serotypes 6B and 23F because these are the main causative serotypes of pneumococcal pneumonia in Japan and these are representative penicillin-resistant pneumococci.11 16 However, the immune response to PPV23 may not be consistent among the 23 serotypes. Lastly, unlike influenza vaccines, antibody levels that are protective against invasive pneumococcal disease in adults have not been clearly defined. We used a 2-fold increase in the IgG concentration or a 10-fold increase in the OI as a measure of positive antibody response to PPV23 in this study, which was also used in previous studies; however, how this threshold may best correlate with protection against invasive pneumococcal disease remains to be determined.

In conclusion, ongoing TCZ therapy does not preclude pneumococcal polysaccharide vaccination in RA patients; however, antibody responses may be reduced when TCZ is administered in combination with MTX.

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Contributors All authors contributed to study conception and design, acquisition of data, analysis and interpretation of data, and drafting of the manuscript with regard to important intellectual content.

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Competing interests TH has received lecture fees from Mitsubishi-Tanabe Pharmaceutical Co., Eisai Co. Ltd. and Abbott Japan Co. Ltd. The other authors have no financial relationships that could lead to a conflict of interest.

Patient consent Obtained.

Ethics approval The ethics committees of participating hospitals approved the protocol for this study.

Provenance and peer review Not commissioned; externally peer reviewed.

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REFERENCES


