Correspondence on ‘SARS-CoV-2 vaccination in rituximab-treated patients: evidence for impaired humoral but inducible cellular immune response’

We read with a great interest the article published by Bonelli et al suggesting an inducible cellular immune response in rituximab (Rtx) treated patients.1 The CD20-antibody Rtx is one of the most widespread biologicals worldwide with a broad spectrum of oncological and rheumatological indications. Due to its depleting effect on circulating B cells, the generation of antibodies against novel pathogens is impaired in Rtx-treated patients.2 3 Accordingly, the last EULAR recommendations on vaccination advised that ‘vaccination should be provided at least 6 months after the last administration and 4 weeks before the next course of B cell-depleting therapy’.4 To ensure appropriate SARS-CoV-2 vaccination, the last EULAR advise was to refer to a rheumatologist.5 The American College of Rheumatology (ACR) has recommended to vaccinate Rtx-treated patients not earlier than 5 months after the last administration with the next cycle given not earlier than 2–4 weeks thereafter.6 In any case, the combination of B cell-depleting therapy with vaccination has been quite a challenge for patients and physicians—especially since it became clear that Rtx therapy may be associated with impaired humoral but inducible cellular immune response’.4 T o ensure appropriate SARS-CoV-2 vaccination in Rtx-treated patients despite a failed humoral immune response.1 The authors demonstrated that peripheral blood cells of vaccinated patients do produce Interferon γ (IFNγ) after stimulation with derived overlapping peptides.1 These results increase the scientific interest into a more detailed characterisation of vaccine-reactive T-cell immunity, which has recently been in the focus of our group as well due to a frequent Rtx application in our settings.

Applying multiparameter flow cytometry, we explored the efficacy of SARS-CoV-2 vaccination as defined by quantification and in-depth characterisation of T cell immunity in nine Rtx-treated patients diagnosed with autoantibodies against myeloperoxidase (MPO), proteinase 3 (PR3), MPO/PR overlap and immunoglobulin A (IgA) vasculitis or membranous glomerulopathy (table 1). Their mean age was 65 years, 33.3% were women, and the mean time after the last application of Rtx was 4.5 months (2–7 months). The vaccination by two doses of BNT162b2 was performed within 3 weeks. SARS-CoV-2-reactive immunity was analysed before the first dose, and 3 weeks after the first and the second dose, respectively. Vaccinated healthcare workers (n=14) served as controls.

All but two Rtx-treated patients had negatetable 1

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Body mass index (kg/m²)</th>
<th>Months since rituximab</th>
<th>Overall rituximab treatment duration</th>
<th>Aetiology</th>
<th>GFR (CKD-EPI; mL/min/1.73²)</th>
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<td>PR3</td>
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GFR, glomerular filtration rate; IgA, IgA-associated vasculitis; MGN, membranous glomerulonephritis; MPO, myeloperoxidase; PR3, proteinase 3.
The role of SARS-CoV-2-specific antibodies in COVID-19 is not well established: reports indicate an increased risk of severe COVID-19 infections in Rtx-treated patients, whereas other data have suggested that B cells are dispensable for resolving such infections. The here presented data indicate that polyfunctional antiviral T cell responses are raised after SARS-CoV-2 vaccination in this high-risk population suggesting protection in the absence of virus-specific antibodies.

Figure 1  Robust polyfunctional T cell response directed against spike (S) wild type (wt) and variants of concern (VOC) strains can be detected in rituximab (Rtx) treated patients following SARS-CoV-2 vaccination. (A) Incidence of Rtx-treated patients responded to the vaccination 3 weeks after the first dose (TP1) and 3 weeks after the second dose (TP2). Vaccine-directed T cell response was defined as >twofold increase of S-reactive T cell frequencies as compared with the prevaccination (TP0) T cell response (CD4+ T cells top; CD8+ T cells bottom). (B) The relative frequency of SARS-CoV-2 reactive CD4+ and CD8+ T cells directed against S-protein of wt, B.1.1.7 and B.1.351 VOC strains in Rtx-treated patients and healthy donors. For CD4+ T cells, activation is defined by CD154+ and CD137+ double expression (top) and for CD8+ T cells by CD137+ (bottom). Presented are data obtained from the last visit (3–5 weeks) after the second vaccination dose. For wt strain, 9 Rtx-treated patients and 14 controls were available. For VOC strains, eight Rtx-treated patients and five controls were available. PBCMs were isolated 3–5 weeks after the second BNT162b2 dose and stimulated overnight with SARS-CoV-2 S-protein of wt, B.1.1.7 and B.1.351 strains, respectively. T cell reactivity was determined by flow cytometry as CD154+, CD137+ and CD137+ for CD4+ and CD8+, respectively, together with antibodies for Granzyme B, IFNγ, TNFα and IL-2. (C) Total frequency of monofunctional (1P), bifunctional (2P) or trifunctional (3P) T cells concurrently producing one, two or three cytokines or no cytokines (0P), respectively, in response to S-protein from wt or B.1.1.7 or B.1.351. PBCMs were isolated 3–5 weeks after the second BNT162b2 dose and stimulated overnight with SARS-CoV-2 S-protein from wt, B.1.1.7 and B.1.351. T cell reactivity was determined by flow cytometry as CD154+ and CD137+ together with antibodies for Granzyme B, IFNγ, TNFα and IL-2. (D) Reduced CD19+ but normal frequencies of other lymphocytes in Rtx-treated patients. The frequencies of CD19+, NK, CD3+, CD4+/CD3+ and CD8+/CD3+ were evaluated in fresh whole blood by flow cytometry. Each point signifies a patient. IFNγ, Interferon γ; IL, interleukin, NK, natural killer, TNFα, tumour necrosis factor α.
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Received 10 May 2021
Accepted 11 May 2021

http://dx.doi.org/10.1136/annrheumdis-2021-220764
Ann Rheum Dis 2021;0:1–3. doi:10.1136/annrheumdis-2021-220756

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REFERENCES