

Immunizations

## Vaccination program in cystic fibrosis

Code: 142

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### Background

CF patients are advised to comply with the recommended vaccination schedule (diphtheria, tetanus, poliomyelitis, acellular pertussis, *Haemophilus influenzae* type B, *Streptococcus pneumoniae*, hepatitis B, measles-mumps-rubella), as well as with hepatitis A and influenza vaccination.

Strategies to prevent CF pathogens such as bacteria of the *Burkholderia cepacia* complex, *Pseudomonas aeruginosa*, or *Mycobacterium*

#### Influenza

As previous observational studies have suggested an adverse outcome in terms of lung function and disease progression in people with CF following infection with Influenza A virus and other viral respiratory tract infections, annual influenza vaccination is commonly recommended in people with CF.

Antiviral agents, including the neuraminidase inhibitors zanamivir and oseltamivir, may also have a place in the prevention and treatment of influenza.

#### Pseudomonas Aeruginosa

Once colonization of the lungs with *Pseudomonas aeruginosa* (PA) occurs in CF, it is almost impossible to eradicate, resulting in progressive lung damage. Vaccines versus PA, aimed at reducing infection with PA, have been developed.

#### Streptococcus Pneumoniae

*Streptococcus pneumoniae* (SP) has been found to be the fourth most common bacterial organism isolated from the sputum of people with CF and for this reason pneumococcal vaccination is recommended.

#### Staphylococcus Aureus and Haemophilus Influenzae

Pulmonary exacerbations in CF are more frequently associated with *Staphylococcus aureus* (SA), PA and *Haemophilus influenzae* (HI). No specific vaccines are available for SA and HI.

#### RSV

The strength of current evidence (only one randomized trial, with limited data) is insufficient to allow conclusions on the use of the palivizumab vaccination to prevent RSV in children with CF (*read the topic "Palivizumab for the prevention of RSV infection in children with cystic fibrosis"*).

### Issues

1. To assess the effectiveness of influenza vaccination particularly on morbidity in the 12 months after vaccination; changes in the rate of progression of lung function, nutritional status, numbers of intravenous antibiotic use, *P. aeruginosa* colonization or infection and death, adverse effects, clinical variability when comparing different types of vaccines.
2. To assess the efficacy of neuraminidase inhibitors for controlling influenza.
3. To assess the effectiveness of vaccination against *P. aeruginosa* in CF and to compare the effects of different vaccines.
4. To assess the efficacy of pneumococcal vaccines in reducing morbidity and mortality in people with CF.

### What is known

#### Issue 1:

1 CDSR ([Dharmaraj P et al. 2014](#)) is available with the aim to compare any influenza vaccine with a placebo. Two out of four studies enrolling 179 subjects with CF (80% were children aged 1 to 16 years) compared an intranasal applied live vaccine to an intramuscular inactivated vaccine and the other two studies compared a split virus to a subunit vaccine and a virosome to a subunit vaccine (all intramuscular). There were no studies comparing a vaccine to a placebo or a whole virus vaccine to a subunit or split virus vaccine. The total adverse events rate ranged from 24% for the intranasal live vaccine to 43% for the split virus vaccine. None of the events was severe. All studies showed a satisfactory serological antibody response generated from influenza vaccinations. However, this response may not result in protection against influenza infection or lung damage. None of the included studies reported clinical outcome measures, such as its impact on PA infection, lung function, length of hospital stay or nutritional status.

A previous phase II, multi-center, adjuvant-controlled trial was performed in RSV seropositive children with CF by purified fusion protein (PFP-3) vaccine developed to prevent severe RSV (151 received the adjuvant-control and 143 received the vaccine). The PFP-3

vaccine induced a robust immune response that lasted throughout the RSV season ([Piedra PA et al. 2003](#)).

According to current practice CF centers recommended vaccination for influenza in people with CF on an annual basis.

1 non-RCT ([Boikos C et al. 2017](#)) involved 198 patients with CF aged 2-19 with CF. Adverse events following live-attenuated intranasal influenza vaccination were most common 0-6 days after LAIV administration, but they were generally benign and self-limiting. Pulmonary exacerbations did not increase in frequency.

**Issue 2:**

1 CDSR (updated 2015) is available. No randomised or quasi-randomised controlled trials on the efficacy of neuraminidase inhibitors for the treatment of influenza infection in people with CF were included in the analysis.

**Issue 3:**

1 CDSR ([Johansen HK et al. 2015](#)) is available comparing PA vaccines (oral, parenteral or intranasal) with control vaccines or no intervention in CF.

Six trials were identified. Two trials were excluded since they were not randomised and one small trial because it was not possible to assess whether it was randomised.

Three trials were evaluated including 483, 476 and 37 patients, respectively. No data have been published from one of the large trials, but the company stated in a press release that the trial failed to confirm the results from an earlier study and that further clinical development was suspended. In the other large trial, relative risk for chronic infection was 0.91 (95% CI 0.55; 1.49), and in the small trial, the risk was also close to one. In the large trial, one patient was reported to have died in the observation period. In that trial, 227 adverse events were registered in the vaccine group and 91 in the control group. There was a marked rise in flagella antibody titres in the vaccine group and no change in the placebo group ( $p < 0.0001$ ). In particular, one study ([Doring G et al. 2007](#)) showed that active immunization of patients with CF with a marked rise in flagella antibody titres lowered the risk for initial infection with PA. Although many of these patients may acquire PA infections later in life, delaying the onset of chronic infection with PA should result in longer survival of these patients. However, several adverse events were registered in the vaccine group compared to placebo group. So vaccines against PA cannot be recommended.

A phase III Study RCT ([NCT01455675](#)) has been completed in order to evaluate clinical efficacy and safety of avian polyclonal anti-pseudomonas antibodies (IgY) in prevention of recurrence of PA infection in CF patients. Results are not available

A post-marketing study to evaluate gargle of solution of anti-pseudomonas IgY every night ([NCT00633191](#)) in preventing recurrence of PA infections in CF patients from 2003 to 2014 has been completed.

**Issue 4:**

1 CDSR is available ([Burgess L et al. 2016](#)).

Several countries as UK and USA include immunization against pneumococcus as part of the routine immunization schedule for children. Children with chronic diseases have a 1.4-fold increased risk of invasive pneumococcal disease compared to healthy children.

In an Italian study the authors ([Giannattasio A et al. 2010](#)) speculate that the low uptake rates of pneumococcal vaccination found in less than 20% of children with CF may be due to a lack of awareness of the severity of pneumococcal disease.

A previous study ([Esposito S et al. 2016](#)) was performed to evaluate *Streptococcus pneumoniae* colonization rates of school-age children and adolescents with CF showed that it is more prevalent than previously thought. Pneumococcal conjugate vaccination administered in the first year of life does not reduce the risk of re-colonization in later childhood and adolescence.

As no controlled trials were identified we cannot draw conclusions on the efficacy of routine pneumococcal immunisation in people with CF in reducing morbidity or mortality.

## Unresolved questions

**Relatively to issue 1:**

There is a need to assess the effectiveness of influenza vaccination on important clinical outcome measures and to define efficacy and safety of different types of influenza vaccines.

**Issue 2:**

Adequately powered, randomised controlled clinical trials have to be performed in order to increase evidence for the effectiveness of these interventions in people with CF.

**Issue 3:**

Caution should be considered for further trials in humans when new vaccines will be developed.

**Issue 4:**

Further epidemiological studies are needed to establish whether pneumococcal vaccines reduce the morbidity and mortality in people with CF. As many countries now include pneumococcal immunisation in their routine childhood vaccination schedule it is unlikely that future randomised controlled trials will be initiated. Longitudinal epidemiological studies may offer the opportunity to evaluate the efficacy of pneumococcal vaccination in reducing morbidity and mortality in people with CF.

## **Keywords**

Influenza A virus; Virus; Immunization;