Defective IgG2 response to *Pneumovax* in HIV seropositive patients

D J Unsworth, D Rowen, C Carne, C Sonnex, T Baglin, D L Brown

Abstract

**Objectives**—To determine whether HIV (Human Immunodeficiency Virus) antibody positive adults are capable of mounting an effective immune response when immunized with polyvalent pneumococcal vaccine.

**Design**—28 patients (nine homosexual men, one bisexual man, three heterosexual females, 10 injecting drug abusers, five haemophiliacs) and 11 healthy volunteers, were immunised with *Pneumovax II* and titres of IgG1 and IgG2 specific antibody measured before and 1 month after immunisation. Magnitude of immune response was related to CD4 T-lymphocyte count at time of immunisation to establish whether responses are better in early disease.

**Main outcome measures**—Based on our data in healthy volunteers we defined an adequate response to *Pneumovax II* as a post immunisation IgG2 antibody level at least 50% greater than the pre immunisation level.

**Results**—The magnitude of the response was significantly higher in the normal volunteers (U = 95; p = 0·0328). Adequate IgG2 responses were seen in 11/11 normals but in only 14/28 HIV seropositives (x² = 8·58; p < 0·01). Poor responses were unrelated to the CD4 T-lymphocyte count at immunisation. Absolute IgG2 deficiency accounted for the poor response in only 1 HIV patient.

**Conclusion**—50% of HIV antibody seropositive individuals fail to mount adequate immune responses to polyvalent pneumococcal vaccine. Non responders are unlikely to be protected.

Patients and materials and methods

Normal individuals are expected to have detectable levels of antibody even before immunisation as a consequence of subclinical exposure to *Streptococcus pneumoniae*. The normal pre immunisation specific IgG2 anti-*Pneumovax* range was established in 38 HIV antibody negative blood donors. Response to intramuscular immunisation with 0·5ml *Pneumovax II* (Merck Sharp and Dohme Ltd, Hertfordshire) was assessed in 11 healthy members of hospital staff aged 24–51 years (four female). Responses were also assessed in 28 HIV seropositive persons aged 21–48 years, including nine homosexual men, one bisexual man, three heterosexual females, 10 injecting drug abusers (five female), and five haemophiliacs. *Pneumovax II* was administered to the haemophiliacs by subcutaneous
injection. One homosexual, one drug abuser, and the bisexual male, had AIDS that is CDC Stage IVc disease. All the other HIV seropositives were CDC Stages II or III. Studies in normal vaccinees showed that antibody responses measured at 2 and 4 weeks post vaccination were identical. Results at 4 weeks post vaccination are reported here.

We used *Pneumovax II* itself as substrate in our ELISA test for specific antibody. All incubation steps were at 25°C. Nunc (Maxisorb) plastic plates were coated overnight with *Pneumovax II* (the undiluted vaccine contains 25 μg of each of the 23 different pneumococcal polysaccharide types), diluted 1/100 in 0-1 M bicarbonate/carbonate buffer pH 9.6. All subsequent incubations were for 2 hours. All dilution and wash steps employed phosphate buffered saline containing 0.05% tween-20. Patients sera were diluted 1/100. Mouse monoclonal antibodies specific for either IgG1 or IgG2 (The Binding Site, Birmingham UK.), and peroxidase labelled rabbit anti-mouse IgG (Dako Ltd UK.) were each diluted to 1/1000. Where samples gave optical density readings outside the linear range of a standard curve run on each assay, samples were diluted and retested. Results are expressed in ELISA units based on serum from an unimmunised blood donor ascribed values of 50 and 15 units in the IgG2 and IgG1 assays respectively. The coefficients of variation for the IgG2 and IgG1 assays were 18% and 16% respectively. With this in mind and based on our experience immunising normal volunteers, we defined a definite response as one where the post immunisation IgG2 antibody level was 50% or more higher than the pre immunisation value (1·5 fold increase in titre). Pre and post immunisation samples were tested side by side on the same ELISA plate. All sera were tested on three separate occasions and the average values taken.

CD4 counts were measured by the whole blood erythrocyte lysis method using a flow cytometer (FACScan with simulset software; Becton Dickinson), with mouse monoclonal antibodies (Leu 3/2; Becton Dickinson) to define and enumerate the CD4+, CD8– lymphocyte population. Total serum IgG1 and IgG2 levels were measured by single radial diffusion in plates obtained from The Binding Site UK. Results are expressed in grams/litre.

### Data analysis

Several of the parameters studied were not normally distributed. We therefore used non-parametric methods of statistical analysis where appropriate. Geometric means are quoted in the figures and throughout the text. Paired data were analysed using the Wilcoxon’s signed-rank test. Non-paired data were analysed using the Mann-Whitney U Test. Correlation between sets of non-parametric data used Spearman’s rank analysis.

### Results

A wide range of pre-immunisation IgG2 anti-*Pneumovax* antibody levels was seen in all three groups (fig 1). None of the HIV group had proven pneumococcal infections in the 6 months preceding immunisation to account for the high antibody levels seen in a minority. Some of the blood donors similarly had high levels of IgG2 specific antibody. Nor were high IgG2 antibody levels pre immunisation in the HIV group related to stage of disease or CD4 count.

Significantly higher levels of IgG2 antibody were found post immunisation for both the hospital staff (*T* = 0; *p* < 0.001), and the HIV group (*T* = 34; *p* < 0.01). However, the magnitude of the response was significantly increased. Figure 1 Titres of specific IgG1 and IgG2 antibody to *Pneumovax II*, pre and post immunisation.

![Figure 1](image1.png)

Figure 2 Lack of correlation between pre-immunisation CD4 lymphocyte count and fold increase in IgG2 specific anti-*Pneumovax II* antibody titre post immunisation. 1·5 fold increase amounts to an increase in specific antibody of 50%. (*t* = 0.0285; *p* > 0.05)

![Figure 2](image2.png)
Defective IgG2 response to Pneumovax in HIV seropositive patients

Figure 3  Lack of correlation between the post-immunisation titre of specific IgG2 anti-Pneumovax II and the pre-immunisation total serum IgG2 level (r = 0.26622; p > 0.05).

Discussion

Our results, in agreement with those of Ballet et al., indicate that approximately 50% of persons infected with HIV fail to mount IgG2 responses to PPPV. Definition of what constitutes an adequate response is difficult. Our ELISA assay will detect both high and low affinity antibody, and data on how much IgG2 antibody is required for protection in man are not available. Failure to elevate antibody levels post immunisation can be regarded as a failed response. Taking into account the 18% coefficient of variation for our assay, an increase of IgG2 specific antibody level of 50% or more was regarded as a definite response. Only 14/28 HIV patients responded. There was no evidence that any of the HIV infected subgroups disproportionately accounted for the poor responders. Suspicions that responses were better in the haemophilic group did not reach statistical significance, and in any case, they were immunised subcutaneously rather than intra-muscularly in contrast to the other groups. Poor responses were independent of CD4 counts at time of immunisation. Although PPPV are composed of T cell independent antigens, the CD4 count was of relevance in this study as a measure of HIV disease progression. Poor responders show no subclass switch to IgG1. The reason for the poor responses in the HIV group is unclear. Absence of IgG2 specific responses raise doubts whether PPPV will provide protection in up to 50% of HIV seropositives.

Our assay has some limitations. For example, where an immune response was demonstrated, we did not check whether the antibodies produced covered all the serotypes present in the vaccine. However, this may actually have caused us to overestimate the number of persons mounting an adequate response. IgM, and IgA antibodies are produced alongside IgG2 antibodies, but as already discussed it is the IgG2 isotype that is believed to be crucial in providing protection. Our decision not to study the other isotypes does not therefore detract from our conclusions. Other authors have studied specific IgM, IgA, and/or total IgG responses to PPPV, and report impaired responses in HIV seropositive individuals.10 There are three prerequisites for a successful immunisation programme. A vaccine of proven efficacy, a target group significantly at risk of infection, and ability of the target group to mount an effective immune response. Our results and those of Ballet et al.11 suggest that in HIV antibody positive patients, the third requirement is not satisfied. A large recent study14 confirmed PPPV efficacy in immunocompetent hospital patients aged less than 55 years, but data in age matched immunocompetent patients were less convincing (HIV patients were excluded from this study). Until similar studies in HIV seropositive are performed, the value of immunising these individuals must remain in doubt.


5 Centres for Disease Control. Recommendations of the immunization practices advisory committee: pneumococcal polysaccharide vaccine. MMWR 1988;5:54-76.


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