To the Editor—The serologic profile of poliovirus neutralizing antibody in patients with acute leukemia prior to vaccination against poliovirus and after treatment for leukemia revealed that almost 11% of patients had protective antibody to all 3 poliovirus serotypes. After 12 months of vaccination, only 47% of patients had protective antibody to all 3 poliovirus serotypes. The antibody titer cutoff used to label disease protection was \( \geq 1:8 \) [1]. Identical susceptibility in children after hematopoietic stem cell transplantation before and after vaccination was 29% and 92%, respectively [2]. With the imminent global control of polio, the antibody titer cutoff level in patients after completion of successful chemotherapy for leukemia or after hematopoietic stem cell transplantation would be worth scrutiny. The prevailing \( \geq 1:8 \) titer might be responsible for false confidence.

The existing cutoff level of \( \geq 1:8 \) has been known to be protective against wild or Sabin attenuated poliovirus strains. This titer might not be adequate against any budding vaccine-derived poliovirus isolates. Recently, type 2 and type 3 evolving or highly divergent vaccine-derived poliovirus isolates were isolated from sewage in Israel. Neutralization data on these isolates demonstrated viral genetic diversity and antigenic divergence. During their neutralization, there was an average 3.3-fold decrease in geometric mean titer, even though the protective antibody titers for Sabin and wild strains exceeded \( \geq 1:8 \). Moreover, 10 (7%) of 150 individuals aged 20–50 years had titers below the minimum protective level of \( \geq 1:8 \) against \( \geq 1 \) vaccine-derived poliovirus strain [3].

Prospective studies to work out the use of simpler vaccination schedules for any earlier vaccinations after successful chemotherapy or transplantations [1, 2] should aim to express polio antibody quantum in international units, rather than use an arbitrary dilution figure. Prospective comparison of inter- and intra-laboratory serologic data would be better illustrated with the use of international units. The antibody content would be more explicit if expressed in international units, rather than using an arbitrary dilution figure. Serologic data on representative post-OPV serum samples from Germany were expressed in such units [4].

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Pneumococcal Vaccination of Children after Hematopoietic Stem Cell Transplantation: Timing Is Crucial

To the Editor—We read with great interest the report by Patel et al. [1] regarding serologic responses to the current British reimmunization schedule among children who have undergone autologous (8 children) or allogeneic (30 children) hematopoietic stem cell transplantation (HSCT). The article elegantly demonstrates that vaccination with tetanus, Haemophilus influenzae type B, meningococcus C, measles, poliovirus serotypes 1, 2, and 3, and heptavalent pneumococcal conjugate vaccines provides a high level of protection against these vaccine-preventable diseases. In the study by Patel and colleagues, vaccination was initiated at \( >12 \) months after autologous and HLA-identical sibling HSCT and at \( >18 \) months after unrelated donor HSCT. On the basis of the significant morbidity and mortality associated with invasive pneumococcal disease within the first year after allogeneic HSCT, we are, however, greatly concerned about the timing of pneumococcal vaccination in the British schedule, in which vaccination was started not earlier than 15 and 21 months after HLA-identical sibling and unrelated donor HSCT, respectively. In this regard, we agree with Chisholm [2], who concludes that the study by Patel and colleagues provides a platform on which further studies should evaluate the earlier start of reimmunization after allogeneic HSCT.

We have recently completed the prospective IKAST vaccination trial (NCT00169728) among pediatric recipients of allogeneic HSCT, in which we aimed to start vaccination as early as 6 months after transplantation. In the