13-Valent Pneumococcal Conjugate Vaccine (PCV13) in Preterm Versus Term Infants

Federico Martín-Torres, MD, PhD; Hanna Czajka, MD; Kimberly J. Center, MD; Jacek Wysocki, MD; Ewa Majda-Stanislawksa, MD; Felix Omeñaca, MD; Enrique Bernaola Iturbe, MD; Daniel Blazquez Gamero, MD; Ana Concheiro-Guisán, MD; Francisco Gimenez-Sanchez, MD; Leszek Szenborn, MD; Peter C. Giardina, PhD; Scott Patterson, PhD; William C. Gruber, MD; Daniel A. Scott, MD; Alejandra Gurtman, MD

OBJECTIVES: This study evaluated the immune response and safety profile of 13-valent pneumococcal conjugate vaccine (PCV13) in preterm infants compared with term infants.

METHODS: This Phase IV, open-label, 2-arm, multicenter, parallel-group study enrolled 200 healthy infants (preterm, n = 100; term, n = 100) aged 42 to 98 days. All subjects received PCV13 at ages 2, 3, 4 (infant series), and 12 (toddler dose [TD]) months, together with routine vaccines (diphtheria-tetanus-acellular pertussis, hepatitis B, inactivated poliovirus, and Haemophilus influenzae type b vaccine and meningococcal group C conjugate vaccine).

RESULTS: Most subjects achieved an anticapsular immunoglobulin G (IgG) antibody concentration ≥0.35 μg/mL for all serotypes: >85% after the infant series (except preterm infants for serotypes 5, 6A, and 6B) and >97% after TD (except for serotype 3). Preterm infants had overall lower IgG geometric mean concentrations compared with term infants; however, geometric mean fold increases after TD were similar for all serotypes. Opsonophagocytic activity results were consistent with IgG results and titers increased after TD in both groups for all serotypes, including serotype 3. PCV13 was generally well tolerated, with similar safety profiles in all preterm subgroups.

CONCLUSIONS: Immune responses were lower in preterm infants than in term infants. However, the majority of subjects in both groups achieved both pneumococcal serotype-specific IgG antibody levels after the infant series that exceeded the World Health Organization–established threshold of protection and functional antibody responses. Responses were uniformly higher after TD, reinforcing the importance of a timely booster dose. PCV13 was well tolerated regardless of gestational age.

WHAT’S KNOWN ON THIS SUBJECT: Preterm infants are at an increased risk of infections; therefore, vaccination is of particular importance. Because immune response data reported for preterm infants may vary according to gestational age and vaccination timing, vaccine responses in this population warrant additional research.

WHAT THIS STUDY ADDS: This study evaluated 13-valent pneumococcal conjugate vaccine in preterm infants. Results suggest that this vaccine was well tolerated and immunogenic; most subjects achieved serotype-specific immunoglobulin G antibody levels and functional antibody responses likely to correlate with protection against invasive disease.
Preterm infants are at increased risk for invasive pneumococcal disease (IPD), particularly infants born at <32 weeks of gestation.\textsuperscript{1,2} This risk may be due to several factors, including reduced materno-fetal transfer of pneumococcal antibodies\textsuperscript{3} and a decreased response to \textit{Streptococcus pneumoniae} due to an immature immune system.\textsuperscript{4} Studies evaluating immune responses of preterm infants receiving pneumococcal vaccinations are scarce, and methodologic differences limit interpretation of the findings.\textsuperscript{2,5–7} However, the data suggest that gestational age (GA) and vaccination timing (eg, allowing for immune maturation) may affect the ability of preterm infants to respond adequately to immunization. To the best of our knowledge, to date, no study has evaluated the 13-valent pneumococcal conjugate vaccine (PCV13) in preterm infants.

The present study evaluated the immunogenicity, safety, and tolerability of a dose schedule of PCV13 given with routine concomitant vaccines to preterm and term infants at 2, 3, 4, and 12 months of age.

**METHODS**

**Objectives**

The study’s primary and secondary objectives were to describe the pneumococcal immune response induced by PCV13 when measured 1 month after the infant series and 1 month after the toddler dose, respectively, in preterm infants compared with term infants (\textgeq37 weeks of gestation). Safety was evaluated in preterm and term infants, as measured by the incidence rates of local reactions, systemic events, and adverse events (AEs).

**Study Design and Subjects**

This open-label, Phase IV, 2-arm, multicenter, parallel-group study was approved by institutional review boards and/or independent ethics committees. It was conducted in compliance with the Declaration of Helsinki, the International Conference on Harmonisation, the Good Clinical Practice Guideline, and all local regulatory requirements.

Subjects were designated preterm or term based on GA at birth. At inclusion, all subjects were considered in generally healthy condition according to investigator judgment based on medical history and physical examination. Exclusion criteria included contraindication to routine pediatric vaccines, bleeding diathesis, history of culture-proven disease caused by \textit{S pneumoniae}, immune deficiency or suppression, and any serious chronic disorders or major illnesses. Between October 2010 and February 2011, a total of 100 subjects per group were screened and enrolled across 5 sites in Poland (50 term and 50 preterm) and 6 sites in Spain (50 term and 50 preterm). Preterm infants were classified according to GA (32 to \textless37 completed weeks; 29 to \textless32 weeks; and \textless29 weeks). Medical history characteristics were collected for all subjects at enrollment. All subjects received PCV13 at 2, 3, 4 (infant series), and 12 (toddler dose) months of age. A long-term follow-up period to evaluate antibody persistence at 12 and 24 months after the toddler dose was ongoing at the time of the present report.

**Vaccines Administered**

The 13-valent pneumococcal conjugate vaccine (Prevnar 13, Wyeth Pharmaceuticals Inc, Collegeville, PA; lot number E09498) contains polysaccharides of pneumococcal serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, and 23F individually conjugated to a nontoxic form of diphtheria toxin cross-reactive material 197. Each 0.5-mL dose, supplied as a single-dose syringe, contains 2.2 \textmu g of each serotype, except type 6B, which contains 4.4 \textmu g. PCV13 was administered by intramuscular injection in the left anterolateral thigh muscle. In accordance with local routine vaccination plans, subjects also received 2 licensed vaccines in the right thigh: diphtheria-tetanus-acellular pertussis, hepatitis B, inactivated poliovirus, and \textit{Haemophilus influenzae} type b vaccine (Infanrix hexa, GlaxoSmithKline Biologicals, Rixensart, Belgium) at 2, 3, 4, and 12 months of age and meningococcal group C oligosaccharide conjugate vaccine (Meningitec, Wyeth Pharmaceuticals Inc) at 2, 4, and 12 months of age.

**Immunogenicity Assessment**

Blood samples were obtained 1 month after the third dose (\textsim5 months of age), just before the toddler dose (\textsim12 months of age), and 1 month after the toddler dose (\textsim13 months of age). Blood samples were collected according to the Directive 2001/20/EC relating to ethical considerations for clinical trials performed in children.\textsuperscript{8} Immune responses, measured by using serotype-specific serum concentrations of anticapsular immunoglobulin G (IgG) and opsonophagocytic activity (OPA) titers to the 13 pneumococcal serotypes in PCV13, were determined for each blood sample. Antcapsular IgG-binding antibody concentrations were measured at each time point by using an enzyme-linked immunosorbent assay with results expressed in micrograms per milliliter;\textsuperscript{5} an OPA microcolony assay\textsuperscript{9} was used to determine functional antibody (OPA) responses to the 13 pneumococcal serotypes, and results were expressed as OPA titers. OPA assays were only performed when serum volume was adequate to conduct the assay. Because of limits on the volume of sera available, the OPA assays were prioritized for the 6 additional serotypes (1, 3, 5, 6A, 7F, and 19A), followed by the 7 common serotypes...
(4, 6B, 9V, 14, 18C, 19F, and 23F). The IgG and OPA testing was performed by Pfizer’s Vaccine Research clinical testing laboratory.

**Safety Assessment**

Parents/legal guardians recorded local reactions (redness, swelling, and tenderness at injection site), systemic events (decreased appetite, irritability, increased sleep, and fever), and antipyretic medication use in an electronic diary on the evening of vaccination and for the next 6 days. AEs and serious AEs (SAEs) were collected from the signing of the informed consent form to 1 month after the toddler dose.

**Statistical Analysis**

Sample size estimation was based on the proportion of subjects achieving an IgG concentration ≥0.35 μg/mL, the threshold of protection established by the World Health Organization by using pooled data from 3 efficacy trials of pneumococcal conjugate vaccines. A sample size of 80 evaluable subjects per group was determined to provide an estimate of the proportion for each serotype to be within 7.6% precision with a 2-sided 95% confidence interval (CI). Assuming a dropout rate of 20%, 200 subjects were enrolled to ensure that 160 subjects were evaluable (received all assigned vaccinations, had blood drawn as required, had at least 1 valid and determinate assay result for the analysis, and had no major protocol violations).

For each serotype, the proportion of subjects achieving an IgG concentration ≥0.35 μg/mL measured 1 month after the infant series was calculated with an exact, 2-sided 95% CI. The between-group difference in the proportion was computed with an exact, unconditional, 2-sided 95% CI and P value. The geometric mean concentration (GMC) ratio of the 2 groups with 2-sided 95% CIs were calculated for each serotype. The same immunogenicity analyses were performed 1 month after the toddler dose. For the 3 preterm subgroups, the aforementioned descriptive statistics were summarized according to preterm subgroup after the infant series and after the toddler dose. OPA results after the infant series and toddler dose were analyzed as for IgG data.

All subjects who received ≥1 dose of PCV13 were included in the safety population. The proportion of subjects with local reactions and systemic events was summarized for each group. AEs were categorized according to the Medical Dictionary for Regulatory Activities and summarized according to group for the infant series and toddler dose. Comparisons between preterm and term infants were constructed by using Fisher’s exact test for proportions. Proportions were derived for the preterm subgroups, with no formal between-subgroup comparisons. All statistical analyses were performed by using SAS version 9.4 (SAS Institute, Inc, Cary, NC).

**RESULTS**

**Preterm Versus Term Infants**

Two hundred subjects were screened and enrolled (100 per group); preterm infants were additionally classified into preterm subgroups according to GA at birth (32 to <37 weeks, n = 25; 29 to <32 weeks, n = 50; and <29 weeks, n = 25). All subjects were white. Mean GA was 30.8 weeks (range: 26.0–36.3 weeks) among preterm infants and 39.5 weeks (range: 37.0–42.0 weeks) among term infants, with a mean birth weight of 1.5 and 3.3 kg, respectively. The number of reported medical history characteristics was higher for preterm infants (83.0%) than for term infants (43.0%) (Table 1, Supplemental Table 6). All subjects completed the infant series; 98% completed the toddler dose. Subject disposition is presented in Fig 1.

One month after the infant series, >85% of subjects achieved an IgG antibody concentration ≥0.35 μg/mL (Table 2); the proportion of responders was statistically significantly lower, however, among preterm infants for serotypes 5, 6A, and 6B compared with term infants. One month after the toddler dose, the proportion of subjects in both the term and preterm groups achieving the 0.35-μg/mL threshold was >97% for all serotypes except serotype 3, with no statistically significant between-group differences (Supplemental Table 7).

**TABLE 1** Demographic and Clinical Characteristics: Evaluable Infant Immunogenicity Population

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Preterm (n = 99)</th>
<th>Term (n = 98)</th>
<th>Total (N = 197)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>48 (48.5)</td>
<td>55 (56.1)</td>
<td>103 (52.3)</td>
</tr>
<tr>
<td>Male</td>
<td>51 (51.5)</td>
<td>43 (43.9)</td>
<td>94 (47.7)</td>
</tr>
<tr>
<td>Ethnicity, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>99 (100)</td>
<td>98 (100)</td>
<td>197 (100)</td>
</tr>
<tr>
<td>Age at 2-mo dose, moa</td>
<td>1.8 ± 0.6</td>
<td>1.5 ± 0.5</td>
<td>1.7 ± 0.6</td>
</tr>
<tr>
<td>Age at 12-mo dose, moa</td>
<td>11.6 ± 0.5</td>
<td>11.6 ± 0.5</td>
<td>11.6 ± 0.5</td>
</tr>
<tr>
<td>GA, wk</td>
<td>30.8 ± 2.6</td>
<td>30.5 ± 1.4</td>
<td>35.1 ± 4.8</td>
</tr>
<tr>
<td>Weight at birth, kg</td>
<td>1.5 ± 0.5</td>
<td>3.3 ± 0.5</td>
<td>2.4 ± 1.0</td>
</tr>
<tr>
<td>Any baseline medical history, n (%)</td>
<td>83 (83)</td>
<td>43 (43)</td>
<td>126 (63)</td>
</tr>
<tr>
<td>Respiratory, thoracic, and mediastinal disorders, %</td>
<td>68.0</td>
<td>42.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Infections and infestations, %</td>
<td>42.0</td>
<td>16.0</td>
<td></td>
</tr>
<tr>
<td>Congenital, familial, and genetic disorders, %</td>
<td>11.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Baseline medical history includes any chronic or significant condition or any relevant surgical procedures occurring before randomization and administration of PCV13. The 2 most common diagnoses by medical history category are shown for each group.

a Mean ± SD.

b Values presented for all enrolled subjects; n = 100 per group.
Pneumococcal IgG GMCs measured 1 month after the infant series, before the toddler dose, and 1 month after the toddler dose were significantly lower for 1 time point in preterm subjects versus term subjects for all serotypes except 14 and 18C and for all time points for 6 of 13 serotypes (6B, 9V, 19F, 23F, 5, and 6A) (Table 3). After the toddler dose, a booster response (ie, post–toddler dose GMC higher than post–infant series GMC) was observed in both preterm and term infants for all serotypes, including serotype 3; preterm infants had GMCs that were significantly lower, however, than term infants for 6 of the 13 serotypes (4, 18C, 1, 5, 6A, and 19A).

Preterm Subgroups

For all preterm subgroups, >85% of subjects achieved an IgG antibody concentration ≥0.35 μg/mL 1 month after the infant series for all serotypes except 3, 5, 6A, 6B, and 23F. For serotypes 6A and 6B, the proportion of subjects achieving this threshold was lower with lower GA (Supplemental Table 9), although no formal statistical analyses were completed. One month after the toddler dose, the proportion of subjects achieving an antibody response ≥0.35 μg/mL was >95% for all 3 preterm subgroups for all serotypes except serotype 3, which was lower with lower GA (Supplemental Table 10).

IgG GMCs 1 month after the infant series were higher for subjects with 32 to <37 weeks’ GA than those with 29 to <32 weeks’ GA and <29 weeks’ GA for all serotypes (Supplemental Fig 2). Before the toddler dose, IgG GMCs were low in the preterm subgroups. After the toddler dose, a booster response was observed for all serotypes except serotype 3 in all preterm subgroups and serotypes 4 and 18C in the <29 weeks’ GA subgroup. Postbooster GMCs were higher in subjects with 32 to <37 weeks’ GA than in the other 2 preterm subgroups.

In contrast to IgG GMCs, which seemed to vary with decreasing GA in some serotypes, a similar consistent trend was not found in OPA GMTs across preterm subgroups (Supplemental Fig 3). OPA GMTs were low and increased for all serotypes in all preterm subgroups after the toddler dose, although no differences based on GA were observed.

Safety Results

The proportion of subjects with local reactions within 7 days after each vaccination was comparable in the preterm and term groups and tended to decrease after each dose in the infant series. The majority of local reactions were mild or moderate (Table 4). Systemic events occurred in a similar percentage of subjects in both groups during the infant series, except for decreased appetite and
irritability or decreased sleep, which were significantly more frequent in the preterm group. The most common systemic event at all doses for both groups was irritability or decreased sleep. The majority of systemic events were mild, with <10% of subjects overall reporting a severe reaction. No subject had fever >40°C during the infant series; 1 term subject experienced fever >40°C during the toddler dose.

During the infant series, 59% of preterm subjects and 55% of term subjects reported an AE (P = .70) (Table 5). Infections, especially respiratory infections, were the most common AEs in both groups. Gastrointestinal disorders occurred significantly more frequently among preterm infants than among term infants (P = .04).

In the period between the infant series blood draw and the toddler dose, approximately equal proportions of subjects experienced AEs (P = .67) (Table 5). The most common AEs in both groups were infections. During the toddler dose (from vaccination through the toddler blood draw), 31% of preterm subjects and 27% of term subjects experienced AEs (P = .53). During this period, 1 subject in the preterm group experienced a vaccine-related AE (rash).

Overall, SAEs occurred in more preterm subjects than in term subjects (14% vs 5%, respectively, during the infant series; P = .051) (Table 5). Only 1% to 2% of subjects experienced SAEs during the toddler dose (1 event of diarrhea in a term infant and 2 events of respiratory infection in the preterm group). One term subject and 1 preterm subject experienced febrile convulsions (139 days after dose 3 and 17 days after dose 4, respectively); neither event was considered vaccine related due to the presence of a simultaneous acute febrile illness (bronchopneumonia and respiratory tract infection, respectively).

Infections were the most common SAEs at all doses, with lower respiratory tract infections predominating. During and after the infant series, SAEs of bronchiolitis, pneumonia, and upper respiratory tract infections were reported in 6, 5, and 2 preterm infants, respectively, and by 2, 1, and 0 term infants. SAEs classified as gastrointestinal disorders were reported for 4 preterm infants and 1 term infant throughout the study.

**DISCUSSION**

This study is the first to evaluate the immunogenicity and safety of PCV13 in preterm infants, a vulnerable population with special respiratory morbidity risk.\textsuperscript{15} Previous studies in preterm infants have shown a reduced response to other conjugate vaccines, including those targeting *H influenzae* type b\textsuperscript{16} and *Neisseria meningitidis* serogroup C.\textsuperscript{17} These data, together with the increased risk of IPD in preterm infants,\textsuperscript{2,18} highlight the need to ensure that preterm infants are immunized and respond adequately to vaccination against *S pneumoniae*.

The current results suggest that preterm infants respond adequately to PCV13 given in a 4-dose series at 2, 3, 4, and 12 months of age. Not unexpectedly, differences between preterm and term infants were observed, with IgG GMCs significantly lower in preterm subjects versus term subjects for 11 of 13 serotypes at ≥ 1 time point and ∼ 50% of serotypes at all measured time points. For some serotypes, lower responses corresponded with lower GA. Although post-toddler dose IgG GMC responses varied according to serotype and GA, the results suggest that adequate priming occurs among preterm infants which is comparable to term infants administered the same vaccination schedule. Differences in IgG response between preterm and term infants almost disappeared after toddler vaccination, emphasizing the importance of timely administration of the booster dose.

In contrast, there were fewer between-group differences in OPA GMTs after the infant series or before the toddler dose; GMTs increased after the toddler dose in both the term and preterm groups, although OPA GMTs were lower among preterm than term infants for 6 of the 13 serotypes. This finding suggests that despite a lower ability to generate serotype-specific antibodies as term infants, the functionality...
The smaller number of subjects contributing sera to the OPA analyses may further limit the between-group comparisons.

For serotype 3, lower IgG GMCs were observed after the booster dose than after the infant series, although postbooster GMCs were higher than pre–toddler dose levels in both preterm and term infants; however, the post–toddler dose OPA GMT was higher than or similar to that measured after the infant series. This unique response pattern observed for serotype 3 is consistent with findings from other studies.\textsuperscript{19,20} Despite this observed phenomenon, studies of early vaccine effectiveness suggest that disease protection is afforded by direct vaccination against serotype 3.\textsuperscript{21,22} Although several methodologic differences exist when comparing this study with previous studies of

<table>
<thead>
<tr>
<th>Serotype</th>
<th>Preterm GMC (95% CI)\textsuperscript{a}</th>
<th>Term GMC (95% CI)\textsuperscript{a}</th>
<th>Comparison of Preterm Versus Term GMC (95% CI)\textsuperscript{b}</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCV7 serotypes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1 mo after infant series</td>
<td>1.96 (1.67 to 2.31)</td>
<td>2.46 (2.04 to 2.97)</td>
</tr>
<tr>
<td></td>
<td>Immediately before toddler dose</td>
<td>0.31 (0.26 to 0.37)</td>
<td>0.41 (0.34 to 0.49)</td>
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<tr>
<td>6B</td>
<td>1 mo after infant series</td>
<td>2.57 (2.18 to 3.03)</td>
<td>3.97 (3.32 to 4.74)</td>
</tr>
<tr>
<td></td>
<td>Immediately before toddler dose</td>
<td>0.75 (0.55 to 0.97)</td>
<td>1.30 (1.00 to 1.67)</td>
</tr>
<tr>
<td>9V</td>
<td>1 mo after infant series</td>
<td>0.48 (0.39 to 0.58)</td>
<td>0.94 (0.79 to 1.11)</td>
</tr>
<tr>
<td></td>
<td>Immediately before toddler dose</td>
<td>4.42 (3.64 to 5.37)</td>
<td>7.27 (6.09 to 8.68)</td>
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<tr>
<td>14</td>
<td>1 mo after infant series</td>
<td>1.06 (0.98 to 1.07)</td>
<td>1.79 (1.50 to 2.13)</td>
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<tr>
<td></td>
<td>Immediately before toddler dose</td>
<td>0.42 (0.32 to 0.53)</td>
<td>0.81 (0.67 to 0.98)</td>
</tr>
<tr>
<td>Additional PCV13 serotypes</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1 mo after infant series</td>
<td>0.54 (0.47 to 0.63)</td>
<td>1.08 (0.92 to 1.28)</td>
</tr>
<tr>
<td></td>
<td>Immediately before toddler dose</td>
<td>0.79 (0.70 to 0.89)</td>
<td>1.39 (1.20 to 1.61)</td>
</tr>
<tr>
<td></td>
<td>1 mo after toddler dose</td>
<td>2.24 (1.96 to 2.56)</td>
<td>3.72 (3.19 to 4.33)</td>
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<tr>
<td></td>
<td>1 mo after infant series</td>
<td>0.56 (0.48 to 0.63)</td>
<td>1.08 (0.92 to 1.28)</td>
</tr>
<tr>
<td></td>
<td>Immediately before toddler dose</td>
<td>0.57 (0.49 to 0.65)</td>
<td>1.11 (0.94 to 1.31)</td>
</tr>
<tr>
<td></td>
<td>1 mo after toddler dose</td>
<td>3.32 (2.83 to 3.89)</td>
<td>5.60 (4.82 to 6.56)</td>
</tr>
<tr>
<td></td>
<td>1 mo after infant series</td>
<td>0.56 (0.48 to 0.63)</td>
<td>1.11 (0.94 to 1.31)</td>
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<td></td>
<td>Immediately before toddler dose</td>
<td>0.57 (0.49 to 0.65)</td>
<td>1.11 (0.94 to 1.31)</td>
</tr>
<tr>
<td></td>
<td>1 mo after toddler dose</td>
<td>3.32 (2.83 to 3.89)</td>
<td>5.60 (4.82 to 6.56)</td>
</tr>
</tbody>
</table>

GMC, geometric mean concentration.

\textsuperscript{a} GMCs were calculated by using all subjects with available data for the specified blood draw. CIs are back-transformations of confidence levels based on Student's t distribution for the mean logarithm of the concentrations.

\textsuperscript{b} Preterm signficantly lower than term: upper limit of 95% CI of GMR < 1.0.

\textsuperscript{c} Serotypes/time points with significant differences between groups.
7-valent pneumococcal conjugate vaccine (PCV7) in preterm versus term infants, including the schedule, timing, and type of vaccine administered, immunogenicity results are consistent with our findings.\(^5\)–\(^7\) Despite observed differences in IgG responses, previous studies suggest that preterm infants can be adequately protected against IPD after receiving a pneumococcal polysaccharide conjugate vaccine. Shinklefield et al\(^2\) reported a vaccine efficacy of 100% in ~4400 preterm infants who received 3 doses of PCV7 with routine vaccinations. In a subset of subjects who had immunogenicity measured, >95% of preterm infants had IgG GMCS $\geq 0.15$ mg/mL, with no difference between preterm and term infants. In an observational study, Rückinger et al\(^23\) found that an infant series of PCV7 prevented IPD in preterm infants, suggesting that pneumococcal polysaccharide

### TABLE 4 Subjects Reporting Local Reactions, Systemic Events, and Antipyretic Use Within 7 Days of Vaccination

<table>
<thead>
<tr>
<th>Variable</th>
<th>Dose 1 Infant Series</th>
<th>Dose 2 Infant Series</th>
<th>Dose 3 Infant Series</th>
<th>Toddler Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preterm</td>
<td>Term</td>
<td>Preterm</td>
<td>Term</td>
</tr>
<tr>
<td></td>
<td>$(n = 86–98)^a$</td>
<td>$(n = 85–99)^a$</td>
<td>$(n = 73–97)^a$</td>
<td>$(n = 76–96)^a$</td>
</tr>
<tr>
<td>Local reactions, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tenderness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>48.9</td>
<td>42.0</td>
<td>48.2</td>
<td>38.6</td>
</tr>
<tr>
<td>Mild</td>
<td>46.2</td>
<td>31.8</td>
<td>43.5</td>
<td>31.0</td>
</tr>
<tr>
<td>Moderate</td>
<td>17.8</td>
<td>16.5</td>
<td>14.3</td>
<td>15.7</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.3</td>
</tr>
<tr>
<td>Swelling</td>
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</tr>
<tr>
<td>Any</td>
<td>39.4</td>
<td>29.2</td>
<td>35.7</td>
<td>42.7</td>
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<tr>
<td>Mild</td>
<td>37.4</td>
<td>28.1</td>
<td>33.7</td>
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<td>Moderate</td>
<td>8.8</td>
<td>8.2</td>
<td>8.0</td>
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</tr>
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<td>Severe</td>
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<td>0</td>
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<td>0</td>
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<td>Redness</td>
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<td>33.7</td>
<td>29.9</td>
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<td>Mild</td>
<td>32.2</td>
<td>28.7</td>
<td>28.0</td>
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<td>Moderate</td>
<td>3.4</td>
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<tr>
<td>Severe</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Any of the above</td>
<td>66.3</td>
<td>57.6</td>
<td>62.9</td>
<td>60.7</td>
</tr>
<tr>
<td>Systemic events, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever $\geq 38^\circ C$</td>
<td>11.6</td>
<td>13.6</td>
<td>27.8</td>
<td>31.6</td>
</tr>
<tr>
<td>$&gt;38^\circ C$ to $39^\circ C$</td>
<td>10.5</td>
<td>13.6</td>
<td>27.8</td>
<td>30.4</td>
</tr>
<tr>
<td>$&gt;39^\circ C$ to $40^\circ C$</td>
<td>1.2</td>
<td>0</td>
<td>0</td>
<td>1.3</td>
</tr>
<tr>
<td>$&gt;40^\circ C$</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>60.9</td>
<td>41.8</td>
<td>61.8</td>
<td>46.4</td>
</tr>
<tr>
<td>Mild</td>
<td>54.9</td>
<td>35.2</td>
<td>55.7</td>
<td>41.7</td>
</tr>
<tr>
<td>Moderate</td>
<td>20.5</td>
<td>17.2</td>
<td>25.3</td>
<td>19.2</td>
</tr>
<tr>
<td>Severe</td>
<td>1.2</td>
<td>0</td>
<td>1.4</td>
<td>0</td>
</tr>
<tr>
<td>Increased sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>67.7</td>
<td>69.5</td>
<td>74.1</td>
<td>64.0</td>
</tr>
<tr>
<td>Mild</td>
<td>60.4</td>
<td>61.3</td>
<td>69.9</td>
<td>59.1</td>
</tr>
<tr>
<td>Moderate</td>
<td>29.9</td>
<td>30.7</td>
<td>34.6</td>
<td>29.5</td>
</tr>
<tr>
<td>Severe</td>
<td>2.3</td>
<td>2.4</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Irritability or decreased sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>84.2</td>
<td>82.5</td>
<td>89.5</td>
<td>77.9</td>
</tr>
<tr>
<td>Mild</td>
<td>77.4</td>
<td>69.5</td>
<td>81.1</td>
<td>71.7</td>
</tr>
<tr>
<td>Moderate</td>
<td>43.5</td>
<td>47.3</td>
<td>64.7</td>
<td>44.2</td>
</tr>
<tr>
<td>Severe</td>
<td>8.1</td>
<td>5.9</td>
<td>17.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Antipyretic medication use</td>
<td>24.4</td>
<td>24.4</td>
<td>24.4</td>
<td>24.4</td>
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<tr>
<td>Any systemic event</td>
<td>90.8</td>
<td>90.9</td>
<td>95.9</td>
<td>88.5</td>
</tr>
</tbody>
</table>

\(a\) Number of subjects reporting the specific characteristic.

\(b\) Mild, hurts if gently touched with no crying; moderate, hurts if gently touched with crying; severe, causes limitation of limb movement.

\(c\) Significant difference between preterm and term groups ($P\leq .05$).

\(d\) Mild, 0.5 to 2.0 cm; moderate, 2.5 to 7.0 cm; severe, >7.0 cm.

\(e\) Mild, loss of appetite but no decreased oral intake; moderate, decreased oral intake; severe, refusal to feed.

\(f\) Mild, increased or prolonged sleeping bouts; moderate, slightly subdued, interfering with daily activity; severe, disabling, not interested in usual daily activity.

\(g\) Mild, easily consolable; moderate, requiring increased attention; severe, inconsolable, crying that cannot be comforted.

\(h\) Includes fever $\geq 38^\circ C$, decreased appetite, increased sleep, and irritability or decreased sleep.
conjugate vaccines can provide functional protection despite a lower quantitative immune response than in term infants.

Similar to results from studies with PCV7,2,5,7,23 PCV13 was generally well tolerated in preterm infants, with no new safety concerns observed. Local reactions and systemic events, including fever, were predominantly mild and had comparable incidences in preterm and term infants. During the infant series, there was a nonsignificant difference in the incidence of any SAE (preterm: 14.0%; full term: 5.0%; P = .051); these events were mainly respiratory and gastrointestinal infections. This finding is not unexpected, as the study was conducted during the winter months when the incidence of these types of infections peaks.24–26 Preterm infants have an increased susceptibility to respiratory infections and are more likely than term infants to have a clinical course that may necessitate hospitalization. Overall, the safety profile observed reflects expected AEs for young infants.

One strength of the present study was its parallel-group design that enabled a direct comparison of immune responses in preterm and term infants. This study evaluated preterm infants with a GA of <29 weeks, an underrepresented population in previous pneumococcal conjugate vaccine studies. One possible limitation of this study was the inclusion of white study subjects only. In addition, the sample size did not allow subgroup comparisons for other outcomes such as OPA GMTs or the identification of rare AEs. Also, because infant weight at the time of vaccination was not measured, the relation between weight and PCV13 response, if any, is unknown. Finally, palivizumab prophylaxis was administered to ~25% of the preterm infants. Whether this treatment influenced immune responses to PCV13 is unclear; however, because palivizumab contains monoclonal antibodies specific for respiratory syncytial virus, interference with PCV13 immune responses is unlikely.27 Moreover, other studies have shown comparable immune responses to PCV7 and the meningooccal groups C and Y and Haemophilus b tetanus toxoid conjugate vaccine in term infants compared with preterm infants who were permitted palivizumab prophylaxis.6,28

In future studies, stratifying the results of our study according to baseline medical conditions may provide further insight into vaccination in this vulnerable population. Epidemiologic studies in preterm infants are also needed to confirm that PCV13 is effective in this population.

**CONCLUSIONS**

Although the immune response to PCV13 one month after the infant series was lower in preterm infants versus term infants, it is likely to provide adequate protection against disease. Although post–toddler dose responses varied according to serotype and GA, priming after an infant series of PCV13 was similar for preterm and term infants. Although the IgG concentrations for serotype 3 after the toddler dose were lower than those achieved after the infant series, the functional OPA antibody levels suggest a similar likelihood of protection for both preterm and term infants. PCV13 was generally well tolerated in the preterm infants when administered on an accelerated schedule, and the observed AEs were consistent with childhood illnesses common in this population. These results reinforce the importance of timely pneumococcal vaccination for all infants, including those born prematurely.

<table>
<thead>
<tr>
<th>AE Infant Series</th>
<th>Preterm (n = 100)</th>
<th>Term (n = 100)</th>
<th>Preterm (n = 100)</th>
<th>Term (n = 100)</th>
<th>Preterm (n = 97)</th>
<th>Term (n = 97)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Event, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any eventa</td>
<td>59.0</td>
<td>55.0</td>
<td>18.0</td>
<td>15.0</td>
<td>31.3</td>
<td>26.8</td>
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<tr>
<td>Gastrointestinal disorders</td>
<td>13.0</td>
<td>4.0b</td>
<td>3.0</td>
<td>1.0</td>
<td>2.0</td>
<td>5.2</td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td>7.0</td>
<td>7.0</td>
<td>1.0</td>
<td>0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Infections and infestations</td>
<td>45.0</td>
<td>41.0</td>
<td>14.0</td>
<td>11.0</td>
<td>27.3</td>
<td>21.6</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>11.0</td>
<td>8.0</td>
<td>1.0</td>
<td>1.0</td>
<td>2.0</td>
<td>0</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>1.0</td>
<td>6.0</td>
<td>3.0</td>
<td>0</td>
<td>3.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>6.0</td>
<td>5.0</td>
<td>0</td>
<td>2.0</td>
<td>6.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>10.0</td>
<td>10.0</td>
<td>1.0</td>
<td>0</td>
<td>5.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td>7.0</td>
<td>5.0</td>
<td>0</td>
<td>2.0</td>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>SAE, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any eventa</td>
<td>14.0</td>
<td>5.0</td>
<td>8.0</td>
<td>9.0</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Infections and infestations</td>
<td>12.0</td>
<td>5.0</td>
<td>7.0</td>
<td>7.0</td>
<td>2.0</td>
<td>0</td>
</tr>
</tbody>
</table>

---

* Number of subjects reporting ≥1 event.
* Significant difference between preterm and term groups in percentages of subjects reporting an event (P ≤ .05).

---

* Number of subjects reporting ≥1 event.
* Significant difference between preterm and term groups in percentages of subjects reporting an event (P ≤ .05).
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Address correspondence to Federico Martinón-Torres, MD, PhD, Translational Pediatrics and Infectious Diseases, Pediatrics Department, Hospital Clínico Universitario de Santiago de Compostela, A choupana s.n. 15701 Santiago de Compostela, Spain. E-mail: federico.martinon.torres@sergas.es

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REFERENCES


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