COVID-19 Vaccination in Patients With Multiple Sclerosis on Disease-Modifying Therapy

Author(s):
Andrew Wolf, MD, MS1; Enrique Alvarez, MD, PhD1

Neurology® Clinical Practice Published Ahead of Print articles have been peer reviewed and accepted for publication. This manuscript will be published in its final form after copyediting, page composition, and review of proofs. Errors that could affect the content may be corrected during these processes.
The COVID-19 pandemic has resulted in challenges for the practice of neurology. One major concern is how to best manage patients with multiple sclerosis who are on disease modifying therapies (DMT). DMTs frequently have immunosuppressive properties that both increase risk for COVID-19 and potentially reduce the immunological response to vaccination in a group already vulnerable to infection due to neurological deficits. Here, we review early data on COVID-19 outcomes in patients with MS and discuss what is known about vaccine effectiveness in those on anti-CD20 and S1PR agents, which are proposed to have attenuating effects based on their mechanisms of action. In addition, we provide recommendations to best utilize novel COVID-19 vaccines in this population and highlight what information may better inform vaccine strategies in the future.
INTRODUCTION

Coronavirus disease 2019 (COVID-19) is a major public health challenge that has resulted in over 2 million deaths worldwide, in addition to extensive economic and social harms. Vaccination for the causative SARS-CoV-2 virus has emerged as a critical mechanism to prevent COVID-19. In this context, there are unique considerations for patients with multiple sclerosis (MS), particularly those patients who are on immunosuppressive disease-modifying therapies (DMT) that may heighten risk for infection, worsen clinical outcomes from infection, and limit responsiveness to vaccines. Here we discuss considerations for COVID-19 vaccination in patients with MS on DMT, as well as recommendations for vaccination planning in this vulnerable population.

DISCUSSION

Patients with MS are at heightened risk of infections, particularly urinary and pulmonary infections. Further, patients with MS are at heightened risk for severe infections (defined by hospitalization) than patients with other autoimmune conditions, which may reflect the contributions of neurological deficits from MS (e.g., bladder dysfunction, dysphagia). Immunomodulatory DMTs, such as glatiramer acetate and interferons, do little to increase risk beyond this baseline, as seen in their respective clinical trials and real world experience. However, immunosuppressive DMTs (particularly anti-CD20s) exacerbate the risk of infection. In the subpopulation treated with anti-CD20 DMT, male gender and time on rituximab increase infection risk, but higher disability is a key factor. While knowledge is evolving, these risks appear to extend to COVID-19. Risk for severe COVID-19 in the MuSC-19 registry (defined as pneumonia, hospitalization, or death) was higher for those patients with MS using anti-CD20 DMT. Older age, longer disease course, higher disability, progressive disease, and the presence of comorbidities were also associated with severe COVID-19 infection. Preliminary data from the MS Global Data Sharing Initiative also suggested that use of anti-CD20 drugs is associated with 1.5x more hospitalizations, 2.5x more intensive care admissions, and 3x more
use of mechanical ventilation compared to other DMTs (Simpson ECTRIMS 2020). However, the COVISEP registry data did not show an association between COVID-19 outcomes and DMT.\textsuperscript{6} Taken together, this suggests that patients with MS, especially in certain groups, may be at increased risk of infection and for poor outcomes, further emphasizing the need for effective vaccination.

Dozens of COVID-19 vaccines are in clinical use or development worldwide; two vaccines are currently being administered in the United States under emergency use authorization granted by the FDA. These vaccines, BNT162b2 (Pfizer-BioNTech) and mRNA-1273 (Moderna) utilize lipid nanoparticle encapsulated mRNA to encode S-2P antigen (modified pre-fusion conformation of the full-length spike protein).\textsuperscript{7} The spike protein is critical for cellular entry of SARS-CoV-2 and these vaccines have demonstrated about 95\% protection against symptomatic COVID-19 infection over a two-month period.\textsuperscript{8, 9} Additional candidates are in phase 3 trials in the United States; some of the other vaccines (notably Oxford-AstraZeneca approved in the United Kingdom) utilize a novel non-replicating adenovirus vector. DMTs may impact the immunological responsiveness to any vaccination since they treat MS by modulating/suppressing the immune system. That said, the extent to which any specific DMT may have an impact on COVID-19 vaccine responsiveness is not known. Current data on the efficacy of vaccines in MS patient on immunosuppressive DMT is limited to traditional vaccine platforms and not the novel mRNA or adenovirus platforms at the forefront of the COVID-19 vaccine programs. With this limitation, there are reasonable concerns about how effective any of the COVID-19 vaccines may be in MS patients on DMTs.

A full review of vaccines in patients with MS is beyond our scope (see Ciotti et al. Mult Scler Rel Dis 2020).\textsuperscript{10} However, completed vaccine studies provide insights regarding if DMTs may impact the efficacy of COVID-19 vaccines. COVID-19 infection induces response in the innate immune system and the adaptive immune system (i.e., antigen-specific cytotoxic T-cells directed against the virus and adaptive B-cell response with ultimate production of novel
antibodies). Higher ratios of IgG antibodies targeting S1 or RBD domains of the spike protein compared to the nucleocapsid protein were associated with milder illness indicating potential importance for specific antibodies; however, the overall antibody response was considered insufficient to predict clinical outcome. Notably, patients with X-linked hypogammaglobulinemia, in addition to most patients with iatrogenic B-cell depletion, can recover from COVID-19 infection indicating that while B-cells may be important in the response to infection, they are not strictly necessary for recovery. There is activation of virus-specific CD4+ and CD8+ T cells in response to BNT162b1, indicating that, at least with mRNA-based vaccines, the protective response may be multifactorial.

The potential for B-cell depleting therapies to attenuate vaccine response is a concern due to their direct effect on humoral immunity and the role of B-cell in antigen presentation. This is concordant with concerns about serological conversion following COVID-19 infection. We are aware of 9 cases of patients with MS who were on anti-CD20 DMT with documented COVID-19 by PCR, but negative serological testing. That said, the portion of patients, if any, who do seroconvert from infection is not known and how any degree of baseline hypogammaglobulinemia impacts this process is similarly uncertain. Broadly, the recent VELOCE trial demonstrated reduced levels of vaccine (tetanus toxoid, pneumococcal 13, influenza) responsiveness and protection, as well as impaired humoral response to stimulatory antigen keyhole limpet hemocyanin (KLH), in patients with MS on ocrelizumab. There is no specific data on vaccine responsiveness in patients with MS on rituximab or ofatumumab; the literature from rheumatoid arthritis suggests that rituximab decreases responsiveness similarly.

The other class of medications concerning for impairing vaccine responsiveness is sphingosine-1-phosphate receptor (S1PR) modulators, which suppress lymphocyte egress from lymph nodes. In a placebo-controlled trial, patients on fingolimod were significantly less likely to respond to influenza and tetanus toxoid vaccines, although the majority still did mount an
appropriate response.20 An additional study evaluating response to influenza vaccination in patients on fingolimod demonstrated reduced response rates when compared to patients not on DMT, in addition to those on glatiramer acetate or interferon beta (neither of which was different from control).21 Like B-cell depleting therapies, fingolimod may prevent seroconversion.22 There is limited data on siponimod with one placebo-controlled study demonstrating reduced responsiveness to vaccination and no published data on ozanimod.23

CONCLUSIONS

Widely available and effective vaccination for COVID-19 is an exciting prospect. While the first FDA-authorized vaccines were given December 2020, the logistics of administration remain challenging. Widespread vaccination may not occur until late 2021. This poses critical questions for patients on or considering initiation of DMT.

For stable patients, continuing current DMT is recommended. Although there is concern that outcomes may be worse and that vaccination may be less effective while on some DMTs, stopping or switching DMT leads to considerable logistical challenges and may lead to rebound disease activity (e.g., for fingolimod). As there is data that the therapeutic effects of rituximab can extend for months beyond the timing of humoral immune reconstitution, it may be possible to extend the dosing interval to create a window to administer the COVID-19 vaccine and allow for immunological response.24 To maximize the immunological response, it is suggested by the Canadian Network of MS Clinics (https://cnmsc.ca/Covid19VaccineGuidance) to wait 4 weeks after the 2nd mRNA vaccine dose for new or repeat infusion of anti-CD20 DMT. For patients already on anti-CD20 DMT, waiting 12 weeks (as in the VELOCE study) after infusion to start the vaccination process is recommended. It has also been proposed to delay vaccination until B-cell reconstitution or towards the end of an infusion cycle, but the risks of contracting COVID-19 need to be considered.

For patients who have not started DMT, considerations for DMT include the expected impact on vaccine efficacy and what other treatment options are available to control the
patient’s MS. If possible, a DMT start could be delayed. The prescribing information for
ocrelizumab recommends that if possible, to vaccinate with non-live vaccines 2 weeks prior to
initiation of treatment (Genentech 2017). As above, it is reasonable to extend this interval to 4
weeks following the second dose of a COVID-19 mRNA vaccine. Additionally, a bridging
strategy could be used by temporarily choosing another DMT. Natalizumab (expected to have
minimal impact on COVID-19 vaccine efficacy) is an alternative and could be used in the short-
term, even in patients who are JC virus positive. Glatiramer acetate, interferon beta, and
dimethyl fumarate are predicted to have relatively minimal impact on COVID-19 vaccination
responsiveness and may be more frequently used.

Further characterizing specific vaccine responses with antibody titers and T-cell
responses in patients on specific DMTs, in addition to clinical outcome data, will be useful in
guiding how to treat and vaccinate MS patients during the COVID-19 pandemic and into the
future. It is recommended that despite uncertainty about vaccination effectiveness, all MS
patients without other contraindications receive a COVID-19 vaccine and follow the AAN
vaccine guidelines. Long-term, more knowledge is needed about the factors that increase
infection rates and how to mitigate them when possible. A comprehensive strategy around
choosing how and when (or not) to treat patients with DMTs as well as developing a vaccination
strategy for COVID-19 and other preventable infections in patients with MS is worthy of further
investigation.

REFERENCES

2. Montgomery S, Hillert J, Bahmanyar S. Hospital admission due to infections in multiple


COVID-19 Vaccination in Patients With Multiple Sclerosis on Disease-Modifying Therapy
Andrew Wolf and Enrique Alvarez

Neurol Clin Pract published online April 14, 2021
DOI 10.1212/CPJ.0000000000001088

This information is current as of April 14, 2021

Updated Information & Services
including high resolution figures, can be found at:
http://cp.neurology.org/content/early/2021/04/13/CPJ.0000000000001088.full.html

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
All Clinical Neurology
http://cp.neurology.org/cgi/collection/all_clinical_neurology
All Demyelinating disease (CNS)
http://cp.neurology.org/cgi/collection/all_demyelinating_disease_cns
All Immunology
http://cp.neurology.org/cgi/collection/all_immunology
All Infections
http://cp.neurology.org/cgi/collection/all_infections
COVID-19
http://cp.neurology.org/cgi/collection/covid_19
Multiple sclerosis
http://cp.neurology.org/cgi/collection/multiple_sclerosis

Permissions & Licensing
Information about reproducing this article in parts (figures,tables) or in its entirety can be found online at:
http://cp.neurology.org/misc/about.xhtml#permissions

Reprints
Information about ordering reprints can be found online:
http://cp.neurology.org/misc/addir.xhtml#reprintsus