Identification of Primary and Secondary Measles Vaccine Failures by Measurement of Immunoglobulin G Avidity in Measles Cases during the 1997 São Paulo Epidemic

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Despite almost universal use of measles vaccines in recent decades, epidemics of the disease continue to occur. Understanding the role of primary vaccine failure (failure to seroconvert after vaccination) and secondary vaccine failures (waning immunity after seroconversion) in measles epidemics is important for the evaluation of measles control programs in developing countries. After a measles epidemic in São Paulo, Brazil, 159 cases previously confirmed by detection of specific immunoglobulin M (IgM) antibodies were tested for IgG avidity, and a secondary immune response, defined by an IgG avidity index of at least 30%, was established in 30% of 159 (18.9%) patients. Among the 159 patients, 107 (67.3%) had not been vaccinated and 52 (32.7%) had received one or more doses of measles vaccine. Of the 107 unvaccinated patients, 104 (97.2%) showed a primary immune response, defined as an IgG avidity index of less than 30%. Among the 52 patients with documented vaccination, 25 (48.1%) showed a primary immune response and 27 (51.9%) showed a secondary immune response, thereby constituting a secondary vaccine failure. Primary vaccine failure was observed in 13 of 13 patients vaccinated prior to 1 year of age and in 43.5 and 12.5%, respectively, of patients receiving one or two doses after their first birthdays. These results provide evidence that measurement of IgG avidity can be used to distinguish between primary and secondary vaccine failures in vaccinated patients with measles; the method can also be a useful tool for the evaluation of measles control programs.
from chronic or past hepatitis C virus infection (18); and for serodiagnosis of many other acute viral diseases (1, 13, 29). Regarding measles infection, the IgG avidity test has been used for estimating the efficacy of measles vaccines (31) and for identifying secondary vaccine failures (25). More recently, it has been proposed that the IgG avidity test for measles may have a potential role in studies of measles vaccine-induced immunity for use as a more effective global measles elimination strategy (26). The aim of the present study was to identify primary and secondary vaccine failures by measurement of IgG avidity in IgM-confirmed measles cases that occurred during the 1997 São Paulo epidemic.

**MATERIALS AND METHODS**

**Population.** The present study was carried out by using the serum samples and the database of a previous investigation, which was undertaken to identify predictors of measles occurrence in children and young adults (<30 years of age) who constituted more than 90% of the measles cases during the 1997 epidemic in São Paulo County (4). In that study, patients’ data, including the measles vaccination status as indicated on the official vaccination cards, were obtained from questionnaires completed during a residential survey carried out from November 1997 to March 1998. This study was approved by the Research Ethics Committee of Instituto Adolfo Lutz, São Paulo, Brazil.

**Criteria for inclusion in study.** The measles cases chosen fulfilled all the following criteria: (i) presence of a rash that met the clinical measles case definition of the Centers for Disease Control and Prevention, (ii) laboratory confirmation of measles by detection of specific IgM antibodies in a sample collected within 30 days after the onset of rash, (iii) patients younger than 30 years, (iv) indication of vaccination status on the official vaccination card, and (v) no vaccination for measles 5 to 21 days prior to the onset of rash.

**Serum samples.** The serum samples for the IgG avidity test were chosen from the serum bank, which is maintained at −20°C at the Laboratory of Exanthematic Viruses of the Instituto Adolfo Lutz.

**Detection of IgM antibodies.** Detection of IgM antibodies was performed by employing a commercial, indirect EIA (Enzygnost-Anti-Measles Virus IgM; Dade Behring, Marburg, Germany) or by an IgM capture EIA (17). In a house enzyme-linked immunosorbent assay as previously described (30). Anti-measles IgG antibody titers, expressed as milli-international units per milliliter, were estimated with serial dilutions of a reference serum provided by the National Institute for Biological Standards and Control (Hertford, England) that were included in each run of our enzyme-linked immunosorbent assay. The titers were calculated from the regression line by using Microsoft Excel. Samples with titers lower than 100 mIU/ml were considered negative.

**Avidity of anti-measles IgG antibodies.** IgG avidity was estimated as previously described (31), with some modifications. This technique is based on the dissociation of low-avidity antibodies upon incubation with urea (14). Briefly, microplates (Nunc-Immuno Plates, Polysorp; Nalge Nunc International) were coated with measles antigen extracted from Vero cells infected with the Toyoshima strain of measles virus and with control antigens obtained from uninfected Vero cells. The microplates were incubated for 1 h at 37°C with 200 μl of blocking solution, which consisted of phosphate-buffered saline (PBS) (pH 7.2) plus 0.05% (vol/vol) Tween 20 (PBST) and 5% (wt/vol) skimmed milk. The blocking solution was then discarded, and 50 μl of serum diluted 1:100 was added in duplicate (two wells containing viral antigen and two wells containing control antigen).

After incubation for 1 h at 37°C, the plates were washed twice with PBST and half the wells were soaked for 5 min with 8 M urea in PBST and half with PBST without urea. After two additional washes, 50 μl of peroxidase-conjugated anti-human IgG (Gibco-BRL) was added. The plates were incubated for 40 min at 37°C and were washed four times with PBST, after which 50 μl of the substrate and chromogen solution (0.03% hydrogen peroxide and 0.4 mg of o-phenylene-diamine per ml in 0.1 M citrate buffer [pH 5.0]) were added. After incubation in a dark chamber for 20 min at room temperature, the enzymatic reaction was stopped by the addition of 50 μl of 2.5 N H2SO4. The plates were read at 492 nm with a microplate spectrophotometer (Titertek Multiskan II).

The results, reported as the difference in optical density (AOD), were calculated by subtracting the optical density obtained for the viral antigen from that obtained for the control wells, which either were or were not treated with urea.

**RESULTS**

The serum samples analyzed were collected up to 27 days after the onset of rash, with 90% of the samples being obtained within 5 days of rash onset. Among the 159 patients enrolled in the present study, 107 (67.3%) had not been vaccinated and 52 (32.7%) had received one or more doses of measles vaccine. Irrespective of vaccination status, a primary immune response was established serologically for 129 (81.1%) patients and a secondary immune response was observed for 30 of 159 (18.9%) patients. One hundred four (97.2%) of the 107 unvaccinated patients showed a primary serological response. Among the 52 patients who had been vaccinated, 25 (48.1%) showed a primary immune response and 27 (51.9%) showed a secondary immune response, thereby constituting a secondary vaccine failure (Table 1).

Analysis of the type of immune response according to age of vaccination and number of vaccine doses showed that 2 of 16 (12.5%) measles patients who received two doses of vaccine after 1 year of age had a primary vaccine failure. This rate was significantly lower than the primary failure rate observed in the group of patients who had received a single dose of vaccine before 1 year of age (13 of 13, 100%; P < 0.0001) or in the group of patients who had received a single dose after 1 year of age (10 of 23, 43.5%; P = 0.04, one-tailed Fisher’s exact test) (Table 2).

**DISCUSSION**

In 1994, the Pan American Health Organization set a goal for stopping indigenous measles transmission in the Americas.
by the end of 2000. In 1996, only nine cases of measles were reported in the city of São Paulo, Brazil. However, in 1997, more than 20,000 cases of laboratory-confirmed measles were reported in that city (6). This outbreak demonstrated that the limited circulation of the measles virus does not indicate the absence of risk for measles outbreaks and highlights several challenges facing those working toward the elimination of measles.

Understanding the role of primary and secondary vaccine failures in measles epidemics is important for the evaluation of measles vaccine control programs in developing countries. A high proportion of primary vaccine failures in vaccinated patients with measles can indicate, for instance, problems in vaccine handling or use of inactive vaccines due to inadequate handling. However, the introduction of enhanced diagnostic tests for IgM detection such as the IgM capture ELISA, results of which may be positive for patients with secondary vaccine failure, resulted in new difficulties for differentiating between primary and secondary vaccine failures (10, 13, 16, 25).

The estimation of IgG antibody avidity is very useful in identifying primary and secondary immune responses, but there have been few reports of its use during measles outbreaks (25). The results of the present study, which show that 18.9% of measles cases confirmed by a positive IgM test exhibited a secondary immune response, provide further evidence that the presence of IgM cannot be used as a reliable indicator of a primary immune response (10, 16, 25, 26).

It is estimated that in highly vaccinated populations, 4 to 8% of measles cases in outbreaks are due to secondary vaccine failure (9, 23). In 1990, more than 27,000 measles cases were reported in the United States, 18.4% of which occurred in subjects vaccinated at least once after reaching 1 year of age. However, the rates of primary and secondary vaccine failures in those cases were not evaluated (5). Vaccination schedules differ considerably from country to country. As a consequence, vaccine failure rates may differ from country to country. Several factors, such as age at vaccination, number of doses received, and immunogenicity of the vaccine strain, may be associated with different rates of primary and secondary vaccine failure (25).

The majority of cases in the present series (107 of 159, 67.3%) occurred in unvaccinated individuals. As expected, 104 of 107 (97.2%) unvaccinated study subjects showed a primary immune response, thereby validating the information given by the IgG avidity test. However, 18.9% of the 159 measles cases analyzed for the present study were associated with a secondary immune response, suggesting that secondary vaccine failures also played an important role in the 1997 São Paulo measles epidemic. Paunio et al. (25), who also used the IgG avidity method, reported a high incidence of secondary vaccine failure during an outbreak of measles in Finland in 1998 and 1999, with rates ranging from 7 to 50% depending on age at vaccination, vaccine strain, and the number of vaccine doses given.

Analysis of the number of vaccine doses and the type of vaccine failure showed that the group of measles patients who had received two vaccine doses after 1 year of age had a rate of primary vaccine failure significantly lower than that of the group of patients who had received a single vaccine dose before 1 year of age or of the group of patients who had received only one dose after 1 year of age. The present study was not designed to evaluate all measles cases that occurred during the 1997 epidemic. However, extrapolating the rate of primary vaccine failures of the present series to the total number of cases in the 1997 measles epidemic in the city of São Paulo, we estimate that about 3,000 cases may have resulted from primary vaccine failure. Most of those cases could probably have been avoided had those patients been given two doses of measles vaccine after 1 year of age (24).

We conclude that IgG avidity can be a useful tool for evaluating primary and secondary vaccine failures during measles outbreaks.

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REFERENCES


TABLE 2. Type of immune response (primary and secondary) in 52 vaccinated patients with measles, as a function of vaccination schedule

<table>
<thead>
<tr>
<th>Vaccination schedule (dose and age)</th>
<th>Total no. of patients</th>
<th>Primary response</th>
<th>Secondary response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 dose at &lt;1 year</td>
<td>13</td>
<td>13 (100.0)</td>
<td>95% CT</td>
</tr>
<tr>
<td>1 dose at &gt;1 year</td>
<td>23</td>
<td>23 (103.5)</td>
<td>23.1–65.5</td>
</tr>
<tr>
<td>2 doses at &gt;1 year</td>
<td>16</td>
<td>16 (12.5)</td>
<td>1.5–38.3</td>
</tr>
</tbody>
</table>


