The Covid-19 Vaccine-Development Multiverse

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Leaving in its wake more than 12 million infections, over 550,000 deaths, and an economic toll in the trillions of dollars to date, the SARS-CoV-2 pandemic has devastated the most vulnerable in our society — adults 65 years of age or older, persons with underlying conditions, and the economically deprived. A vaccine is urgently needed to prevent Covid-19 and thereby stem complications and deaths resulting from transmission of the disease.

Jackson et al. now report in the Journal preliminary findings from a phase 1 trial to evaluate the safety and immunogenicity of an mRNA SARS-CoV-2 vaccine. Phase 1 involves 45 healthy adults, 18 to 55 years of age, who were assigned to receive the candidate vaccine at one of three dose levels (25 μg, 100 μg, or 250 μg) given as two vaccinations 28 days apart. These preliminary findings represent the first of three reports of data from a phase 1 study of this candidate vaccine; a second report including similar data from adults older than 55 years of age and a final report summarizing the safety and durability of immunity for both study cohorts are also planned.

The speed with which this vaccine has been developed is remarkable — from publication of the first SARS-CoV-2 sequences through phase 1 in 6 months, as compared with a typical timeline of 3 to 9 years (Fig. 1). The rapid pace of development of vaccines against Covid-19 is enabled by several factors: prior knowledge of the role of the spike protein in coronavirus pathogenesis and evidence that neutralizing antibody against the spike protein is important for immunity; the evolution of nucleic acid vaccine technology platforms that allow creation of vaccines and prompt manufacture of thousands of doses once a genetic sequence is known; and development activities that can be conducted in parallel, rather than sequentially, without increasing risks for study participants.

The safety and immunogenicity data in this preliminary report are promising, and they support continued development of this vaccine. However, we must bear in mind the complexity of vaccine development and the work still to be done before Covid-19 vaccines are widely available.

Many phase 3 studies fail because of incorrect identification of the dose that best balances safety and efficacy. The dosing regimen for this mRNA vaccine is still under study. The 250-μg dose did not appear to be associated with markedly higher antibody titers than the 100-μg dose, but it was associated with a higher proportion of severe systemic adverse events. As the investigators indicate, it is prudent to evaluate doses of 100 μg and lower to define the regimen that provides the most appropriate benefit–risk profile for this vaccine. Another special dosing consideration in this case is age: the immune functions that decline with age and that are likely to be responsible for the greater risk of severe Covid-19 in older adults may also lead to poor vaccine responses. Will a high-dose Covid-19 vaccine be needed for effective protection of older adults, as observed with influenza vaccines?

The clinical significance of SARS-CoV-2 binding and neutralizing antibody titers and their ability to predict efficacy will need to be confirmed. These measures are currently being used to guide dose selection before being verified; they are the best tools available and are supported by findings in nonhuman primates. Confirmation of the correlation between antibody titers and protection against Covid-19 will be possible only in a large clinical efficacy study. In the meantime, the validity of the assays for measuring antibody will also need to be documented. These assays are
Can the vaccine multiverse do it again, leading to a reality of a safe, efficacious Covid-19 vaccine for the most vulnerable in the next 6 months?

Disclosure forms provided by the authors are available with the full text of this editorial at NEJM.org.

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