By the age of five years, between 1 in 40 and 1 in 77 children in Europe and the USA will have been hospitalised for rotavirus diarrhoea. Although health care and economic costs of the illness are high, mortality in developed countries is very low. In contrast with the developing world, and despite considerable efforts to educate carers in simple oral rehydration therapy, it is estimated that 600 000–800 000 children, or 1 in 40 children in the first five years of life, die annually from rotavirus infection. 1 The advantages of an oral rotavirus vaccine thus seem self evident: economic benefits to the developed world and significantly reduced infant mortality in the developing world. Candidate rotavirus vaccines were first developed by tissue culture adaptation and attenuation of bovine and rhesus rotaviruses. Subsequently, such heterologous rotaviruses were improved for use as human vaccines by reassortment with human rotaviruses. After favourable results of prelicensing trials in the USA and Finland2 showing vaccine efficacies of 60% and 91% for reduction of all and serious rotavirus infections, respectively, the US food and drug administration licensed an oral tetravalent rhesus-human reassortant rotavirus vaccine (RRV-TV) in August 1998. Distribution of the vaccine for incorporation into infant schedules commenced in the USA in October 1998. By the end of May 1999, when approximately 1.5 million doses of RRV-TV vaccine had been distributed, nine cases of intussusception in infants who had received RRV-TV had been reported to the Vaccine Adverse Event Reporting System, as compared with only four reports to that organisation in the preceding seven years.3 As a result of these data, the vaccination programme was initially suspended and the company withdrew the vaccine from the market in October 1999. Three questions arise as a result of these actions:

- was this a true effect?
- what was the mechanism of the effect?
- what are the ethical implications?

The first of these questions was carefully addressed in the recently published investigation by the Rotavirus Intussusception Investigation team of the Centres for Disease Control (CDC) in the USA.4 The study was based on retrospective case controlled and case series analyses of infants aged 1–12 months, hospitalised with radiologically or operatively confirmed intussusception between 1 November 1998 and 30 June 1999 across the 19 states of the USA where 80% of the administered RRV-TV had been distributed. Of the 446 infants identified with intussusception, 429 were included in the study (96%). A total of 17.2% of the patients with intussusception and 12.8% of the controls had received RRV-TV (p = 0.02). The severity of intussusception was not significantly different in control and vaccinated patients. In the RRV-TV group, the risk of intussusception was greatest in the 3–14 days after any dose of vaccine, with an odds ratio of 10.6. This translated to an odds ratio of 21.7 after the first dose when the majority (64%) of cases occurred. The authors estimated that if the RRV-TV programme were fully implemented across the USA, between 4670 and 9474 infants would be vaccinated for each case of intussusception attributable to RRV-TV. They concluded that their data provided evidence of a strong temporal and specific link between RRV-TV and intussusception.

The CDC’s retrospective study was not designed to address the aetiology of the link between RRV-TV vaccine and intussusception. Indeed, the pathogenesis of intussusception in infants is poorly understood. The observation of mesenteric lymphadenopathy or inflamed Peyer’s patches in a significant proportion of cases points to an inflammatory process. This has been linked to a number of viral infections: commonly adenovirus, but also human herpes virus (HHV)-6, HHV-7, Epstein-Barr virus, and cytomegalovirus.4 Although uncommon, wild rotavirus infection has also been
identified in infants with intussusception.7 The incidence of this complication may be serotype
dependent,8 possibly because some serotype specific rotaviral enterotoxins can
cause lymphoid hyperplasia and increased intestinal peristalsis.9 This clearly has implications for the selection
of serotypes in novel rotavirus vaccines.

The third question raised by this vaccine experience is an ethical one. Withdrawal of RRV-TV by the manufac-
turer has huge implications for the developed world, where the benefits in
terms of reduction in infant mortality are likely to be most significant. To date, the only trials of the vaccine outside
Europe and the USA have been in South America, which differ from those
to the prevalent rotavirus serotypes in
the USA and Europe,10 which has a similar serotype distribution
studies have been undertaken in Africa,
and thus where one might predict similarly good vaccine
efficacy. While the risk-benefit analysis
for RRV-TV and related vaccines may be favourable in some parts of the world,
withdrawal of one rotavirus vaccine is likely to make pharmaceutical compa-
nies wary of pursuing current or future rotavirus vaccine developments.

There is little doubt of the worldwide
need for an effective and safe rotavirus vaccine. However, without a full under-
standing of the pathophysiology of intest-
tinal intussusception, it will be difficult
to design vaccines that avoid this compli-
cation.

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Gut 2002 50: 11-12
doi: 10.1136/gut.50.1.11

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