LETTER TO THE EDITOR

Do we really want to end meningococcal disease (and current inequity)?

¿Queremos o no acabar con la enfermedad meningocócica (y la inequidad actual)?

Dear Editor:

The actual meningococcal vaccine coverage in Spain exceeds official estimates, so the epidemiological trends that we measure do not correspond to the official immunization schedule covered by the state, but to the coverage achieved by parents and paediatricians that adhere to the schedule recommended by the Asociación Española de Pediatría (Spanish Association of Pediatrics). It is difficult to understand the decision of the Interterritorial Council to once again neglect the opportunity to update its meningococcal vaccination strategy for year 2022. There are also disparities between autonomous communities in Spain which, on one hand, accept the “unified” nationwide schedule but then complement it as they consider appropriate, giving rise to 4 different meningococcal vaccination schedules in Spain (Fig. 1). This state of affairs exacerbates existing inequities based on the residential zip code in the protection of children against meningococcal disease. Establishing the optimal schedule for vaccination against meningococcal disease is not an easy task, and there is wide variability within Europe alone, with differences that cannot be explained based on epidemiological or other logical criteria. In my opinion, given the uncertainty, the best approach is to offer the broadest possible coverage, including both serogroups B and ACWY and with vaccination of both infants and adolescents (Fig. 2). The decision in Spain of vaccinating adolescents against the ACWY serogroups (MenACWY vaccine) may be useful in the medium term, given based on the class effects of conjugate vaccines on carriers and the positive outcomes of this strategy observed in the United Kingdom. However, the current coverage rates cannot achieve indirect protection of unvaccinated individuals, except against group C. Once the herd immunity threshold can be reached through a high and sustained vaccination coverage in the cohort of adolescents vaccinated with MenACWY vaccine, it would be possible to do away with the doses given in infancy. In the case of group B, since vaccination has no impact on carriers, the vaccine will only offer direct protection. There are no data confirming the need of a booster dose of meningococcal B vaccine in older children or adolescents correctly vaccinated with the pri-

Figure 1  Current schedules for vaccination against meningococcal disease in Spain. As of April 2022, there are at least 4 different meningococcal vaccination schedules, 3 of which offer greater coverage and diverge from the unified schedule established by the Interterritorial Council of the National Health System, which constitutes a source of inequity based on the residential zip code.
primaryseriesininfancy,northata single dose at this time wouldbesufficienttomaintainprotectionortoobtainthepotentialbenefitsofcross-protectiondescribedinthe literatureforthisagegroup.However,vaccinationofadolescents againstgroup B meningococcus is important for their protection,as they are the age group with thesecondhighest incidenceofmeningococcaldiseasethatispossiblethat these conjugate vaccines may offer a clinically significant degree of cross-protection against gonorrhoea, a disease that is exhibitingamarkedsurgeforwhichtherewerenospecificvaccines.

Meningococcaldiseaseisasingleillness, but it is caused by differentserogroups, andtoday safe and effective vaccinesare available that offer coverageagainst the groups involved in nearly all cases that occur in Spain. If we really want to controlemeninococcal disease andare seriousabout pursuing the goal of a meningitis-free world by 2030, a target set by the World Health Organization, the official immunization schedule of Spain should take a comprehensive approach, offering coverage against every serogroup for whichit is availableand protecting infants as well as adolescents. Each case of meningococcaldisease in Spain shouldbesidconsideredapublichealthfailure.

**Conflict of interests**

FM-T hasreceivedfeesas an advisor, consultant or lecturer from Biofabri, GSK, Pfizer Inc., Sanofi Pasteur, MSD, Seqirus, Novavax and Janssen in areas unrelated to the subject of this article. FMT has been the principal investigator in clinical trials funded by the same pharmaceutical companies in addition to Abylnx, Regeneron, Roche, Abbott and Medimmune, for which the fees were paid to the institution FMT is affiliated to.

**References**


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