**Improved Clinical Outcome of COVID-19 in Hematologic Malignancy Patients Receiving a Fourth Dose of Anti-SARS-CoV-2 Vaccine: An EPICOVIDEHAR Report**

Jon Salmanton-García¹,², Francesco Marchesi³, Andreas Glenthaöj⁴, Yavuz M. Bilgin⁵, Jens van Praet⁶, Julio Dávila-Valls⁷, Sonia Martin-Pérez⁷, Jorge Labrador⁸, Jaap van Doesum⁹, Iker Falces-Romero¹⁰, Francesca Farina¹¹, Martin Schönlein¹², Mathilde Chanut¹³, Verena Petzer¹¹, Ildelonso Espigado¹⁵, Micheline Dargenic¹⁶, Aminash Auyayev¹⁷, Uluhani Sili¹⁸, Laura Serrano¹⁹, László Imre Pinczés²⁰, Nick de Jonge²¹, André Soto-Silva²², Caterina Buquicchio²³, Lucia Prezioso²⁴, Monia Marchetti²⁵, Stef Meers²⁶, Alessandro Busca²⁷, Paolo Corradini²⁸, Martin Hoening²⁹, Philipp Koehler², Laman Rahimi¹,², Gökçe Melis Çolak¹, Elena Arellano³², Dominik Wölf³³, Stefanie Gräfe¹,²,³⁴, Emanuele Ammatuna⁸, Caroline Berg Venemyr⁴, Oliver A. Cornely¹,²,³⁵,³⁶, Livio Pagano²⁷,³⁸

**Correspondence:** Jon Salmanton-García (jon.salmanton-garcia@uk-koeln.de).

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) causes life-threatening COVID-19 in hematologic malignancy (HM) patients, associated with high morbidity and mortality in this particularly vulnerable population.¹ After more than 2 years since the beginning of the COVID-19 pandemic, several prophylactic and therapeutic strategies have been developed against SARS-CoV-2, including targeted antivirals, monoclonal antibodies and vaccines, leading to improved clinical outcomes.²³

1. University of Cologne, Faculty of Medicine and University Hospital Cologne, Translational Research, Cologne Excellence Cluster on Cellular Stress Responses in Aging-Associated Diseases (CECAD), Germany
2. University of Cologne, Faculty of Medicine and University Hospital Cologne, Department of Internal Medicine, Center for Integrated Oncology Aachen Bonn Cologne Duesseldorf (CIO ABCD) and Excellence Center for Medical Mycology (ECMM), Germany
3. Hematology and Stem Cell Transplant Unit, IRCCS Regina Elena National Cancer Institute, Rome, Italy
4. Department of Hematology, Copenhagen University Hospital—Rigshospitalet, Denmark
5. Department of Internal Medicine, ADRZ, Goes, the Netherlands
6. Department of Nephrology and Infectious diseases, AZ Sint-Jan Brugge, Oostende AV, Belgium
7. Hospital Nuestra Señora de Sonsoles, Ávila, Spain
8. Department of Hematology, Research Unit, Hospital Universitario de Burgos, Spain
9. University Medical Center Groningen, the Netherlands
10. La Paz University Hospital, Madrid, Spain
11. IRCCS Ospedale San Raffaele, Milan, Italy
12. Department of Oncology, Hematology and Bone Marrow Transplantation with Section of Pneumology, University Medical Center Hamburg-Eppendorf, Germany
13. Centre Hospitalier de Versailles, Le Chesnay, Université Paris-Saclay, UVSQ, Inserm, Équipe “Exposome and Hérédité”, CESP, Villejuif, France
14. Department of Hematology and Oncology, Comprehensive Cancer Center Innsbruck (CCCI), Medical University of Innsbruck (MUI), Austria
15. Universitätsklinikum Hamburg Eppendorf, Germany
16. Clinical Trials Centre Cologne (ZKS Köln), Center for Molecular Medicine Cologne (CMMC), University of Cologne, Faculty of Medicine and University Hospital Cologne, Germany
17. German Centre for Infection Research (DZIF), Partner Site Bonn-Cologne, Cologne, Germany
18. Hematology Unit, Fondazione Policlinico Universitario Agostino Gemelli - IRCCS, Rome, Italy
19. Hematology Unit, Università Cattolica del Sacro Cuore, Rome, Italy
20. University of Milan and Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy
21. Division of Infectious Diseases and Global Public Health, Department of Medicine, Clinical and Translational Fungal-Working Group, University of California San Diego, CA, USA
22. Department of Infectious Diseases, Department of Internal Medicine, Medical University of Graz, Austria
23. Marmara University, Istanbul, Turkey
24. Department of Hematology, University Hospital Virgen Macarena, Seville, Spain
25. Department of Hematology and Oncology, Comprehensive Cancer Center Innsbruck (CCCI), Medical University of Innsbruck (MUI), Austria
26. Universitätsklinikum Hamburg Eppendorf, Germany
27. Stem Cell Transplant Center, AOU Città della Salute e della Scienza, Turin, Italy
28. Hospital University of Parma - Hematology and Bone Marrow Unit, Parma, Italy
29. Azienda Ospedaliera Nazionale SS. Antonio e Biagio e Cesare Amigo, Alessandria, Italy
30. AZ KLINIK, Brasschaat, Belgium
31. University of Milan and Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy
32. Department of Hematology, University Hospital Virgen Macarena, Seville, Spain
33. Department of Hematology and Oncology, Comprehensive Cancer Center Innsbruck (CCCI), Medical University of Innsbruck (MUI), Austria
34. Stem Cell Transplant Center, AOU Città della Salute e della Scienza, Turin, Italy
35. University of Milan and Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy
36. Department of Hematology, University Hospital Virgen Macarena, Seville, Spain
37. Department of Hematology and Oncology, Comprehensive Cancer Center Innsbruck (CCCI), Medical University of Innsbruck (MUI), Austria
38. Universitätsklinikum Hamburg Eppendorf, Germany
39. Centre Hospitalier de Versailles, Le Chesnay, Université Paris-Saclay, UVSQ, Inserm, Équipe “Exposome and Hérédité”, CESP, Villejuif, France
40. Department of Hematology and Oncology, Comprehensive Cancer Center Innsbruck (CCCI), Medical University of Innsbruck (MUI), Austria
41. Clinical Trials Centre Cologne (ZKS Köln), Center for Molecular Medicine Cologne (CMMC), University of Cologne, Faculty of Medicine and University Hospital Cologne, Germany
42. German Centre for Infection Research (DZIF), Partner Site Bonn-Cologne, Cologne, Germany
43. Hematology Unit, Fondazione Policlinico Universitario Agostino Gemelli - IRCCS, Rome, Italy
44. Hematology Unit, Università Cattolica del Sacro Cuore, Rome, Italy
45. JS-G and FM contributed equally to this work.

Received: July 18, 2022 / Accepted: September 6, 2022

http://dx.doi.org/10.1097/HS9.0000000000000789.
to improved prognosis in HM patients. Our preliminary data in vaccinated HM patients with COVID-19 reported a significant reduction in disease severity and mortality rate, however, still exceeding the mortality rate in the overall population.

As a consequence of breakthrough SARS-CoV-2 infections in fully vaccinated patients who had received a booster or third dose, a second booster or fourth dose was approved in Europe at the beginning of 2022. Despite the absence of strong clinical evidence, target populations were defined as advanced age or high-risk individuals (e.g., patients suffering from HM) who had received a third dose at least 4 months before. However, the lack of consolidated data has resulted in a general skepticism on anti-SARS-CoV-2 fourth dose efficacy among both, the public and the scientific community. As a consequence, so far even among HM patients, only a very few individuals received a fourth dose, despite several data supports the low immunogenicity of anti-SARS-CoV-2 vaccine in this patient population, particularly in those treated with immunosuppressive agents.

Here, we report the clinical presentation and outcome of COVID-19 occurring in a cohort of HM patients who had previously received a fourth anti-SARS-CoV-2 vaccine dose registered in the EPICOVIDEHA registry.

EPICOVIDEHA (clinicaltrials.gov: NCT04733729) is an open online registry gathering clinical data from COVID-19 patients with baseline HM, hosted at www.clinicalsurveys.net (EFS Summer 2021, TIVIAN, Cologne, Germany). The survey is an initiative of the European Hematology Association—Infectious Diseases Working Party (EHA-IDWP), with a central approval from the Institutional Review Board and Ethics Committee of Fondazione Policlinico Universitario A. Gemelli—IRCCS—Università Cattolica del Sacro Cuore, Rome, Italy (Study ID: 3226). When applicable, the respective local ethics committee of each participating institution approved the project. Detailed EPICOVIDEHA methods have been described elsewhere. Each documented patient was reviewed and validated by infectious diseases and hematology experts from the coordination team. Inclusion criteria were (1) active HM within the last five years before COVID-19 diagnosis, (2) patients ≥18 years old, (3) laboratory-based diagnosis of SARS-CoV-2 infection, and (4) reception of a fourth anti-SARS-CoV-2 dose before COVID-19 diagnosis. COVID-19 severity was graded according to international standards, as previously described. Between April 2022 and June 2022, up to 160 contributors could provide data from more than 40 countries. Categorical variables have been summarized in frequencies and percentages, whereas continuous variables in median and interquartile range (IQR). No further inferential analyses have been performed due to the limited sample size.

As of August 2022, 7302 HM patients with SARS-CoV-2 infection have been registered in the EPICOVIDEHA registry. Of these, 102 (1.4%) were diagnosed with COVID-19 after having received a fourth vaccine dose (Table 1); these patients were registered from 23 sites located in 12 European countries. In the large majority of cases (94%) this was the first occurrence of COVID-19, whereas only 6 patients had been already affected by COVID-19 in the past. Most of those (66/102, 64.7%) were male; median age was 69 years (IQR 62–75) comprising only 9 patients (8.8%) below the age of 50 years.

Almost 50% of the patients had an underlying chronic cardiopathy (50/102, 49.0%), 15.7% (16/102) suffered from diabetes mellitus, and 12.7% (13/102) had a chronic pulmonary disease. Categorical variables have been summarized in frequencies and percentages, whereas continuous variables in median and interquartile range (IQR). No further inferential analyses have been performed due to the limited sample size.

Almost 50% of the patients had an underlying chronic cardiopathy (50/102, 49.0%), 15.7% (16/102) suffered from diabetes mellitus, and 12.7% (13/102) had a chronic pulmonary disease. Categorical variables have been summarized in frequencies and percentages, whereas continuous variables in median and interquartile range (IQR). No further inferential analyses have been performed due to the limited sample size.
baseline acute myeloid leukemia (AML)/high-risk myelodysplastic syndrome. Most patients had a controlled HM at the time of COVID-19 diagnosis (63/102, 61.8%), whereas the remaining suffered from active disease (38/102, 37.3%). More than half of the patients (58/102, 56.9%) received immunotherapy as the most recent antineoplastic treatment before COVID-19, the majority of which (42/58, 72.4%) received therapy within 3 months before COVID-19 diagnosis. At the time of COVID-19 diagnosis, neutrophil counts were higher than 1000/mm³ in 68 patients (66.7%) and lymphocyte counts were above 500/mm³ in 58.8% (60/102).

Patients received the fourth vaccine dose at a median of 42 days (IQR 20–62) before COVID-19 diagnosis, almost exclusively mRNA based (101/102, 99.0%). Genotyping of the VOC was performed in 43.2% (44/102) of patients and identified the Omicron variants in all samples but one; the most frequently reported sub-variants was BA.2 (Table 1). COVID-19 remained asymptomatic or mild in almost all cases (59/102, 57.8%), whereas 39 cases were defined as severe (38.2%); only 4 cases of critical infection (3.9%) requiring intensive care. Hospital admission rate was 38.2% with a median hospital stay of 10 days (IQR 7–21). Only 56 patients (54.9%) received a specific treatment for SARS-CoV-2, with almost all of them (26/56, 46.4%) receiving monoclonal antibodies. Patients were followed up for a median of 54 days (IQR 27–83) and only four died (3.9%); in two cases the death was attributable to COVID-19, whereas in the others 2, it was due to both COVID-19 and HM. All patients were older than 70 years, 3 (75%) had comorbidities, were affected by relapsed/refractory lymphoproliferative malignancies and were receiving immunotherapy at the time of COVID-19. In both cases genotyping revealed the Omicron BA.2 variants.

To the best of our knowledge, no studies have been previously published regarding clinical presentation and outcome of COVID-19 in HM patients who had received the second anti-SARS-CoV-2 vaccine booster (fourth dose). From April to August 2022, we collected 102 cases in EPICOVIDEHA who had breakthrough COVID-19 after 4 vaccine doses. Viral genotyping was available in only 43.2% of patients but showed consistently Omicron VOC. Considering the trajectory of the pandemic, we assume that all cases registered most likely are attributable to Omicron. The clinical presentation was different from reports in the prevaccination era and in our previous study on breakthrough infections in HM patients who had received two vaccine doses. After the fourth vaccination doses, the rate of severe/critical cases observed in patient with COVID-19 was significantly lower when compared to our previous reports (63.8%/70% versus 42.1%, \( P < 0.001 \)). Accordingly, we observed a very low overall mortality rate, since only 4 deaths were reported (3.9%) in patients receiving four vaccination doses. The largest number of patients presented with mild symptoms (48.0%) and most of them were easily managed at home.

About half of patients received specific treatments, mostly monoclonal antibodies and only a few patients received antiviral compounds. These data are interesting and even more impressive if compared with our previously published experience on a large cohort of HM patients with Omicron VOC infection, in which we found an hospital admission rate (52%) and overall mortality rate (8.6%). Of note, in this last study, at least 1 vaccine dose had been administered to 93.1% of patients, but only a very few of them (1%) received a fourth dose.\(^1\) In accordance with several reports, most patients were affected by lymphoproliferative malignancies, and baseline demographic and clinical characteristics were similar to those observed in our previous experiences and in the prevaccination era.\(^1,2\) Moreover, the majority of our patients were treated with immunotherapy or targeted treatments, both of them well recognized risk-factors for poor response to anti-SARS-CoV-2 vaccines.\(^11\) Interestingly, in this series we found only 15 patients affected by myeloproliferative malignancies (14.7%); this is consistent with the putative higher immunogenicity of anti-SARS-CoV-2 vaccine in patients affected by myeloid malignancies.\(^12\) Consistently, 4 of 8 AML patients reported in our cohort had previously received allogeneic stem cell transplant, which probably made them less capable of mounting an adequate humoral immune response, as observed in lymphoproliferative malignancies.\(^8\)

Unfortunately, we had too little data about serological responses upon the fourth vaccine dose, since a post-vaccine evaluation of anti Spike immunoglobulin G was not routinely assessed at the enrolling sites; this is a weakness of our study limiting the understanding of the real efficacy of the fourth vaccine dose, at least in terms of its capability to induce humoral immune responses. Moreover, from our data it’s difficult to definitely establish whether the prognosis improvement is truly related to the 2 extra booster vaccine doses. The success of vaccination strategies is likely a major but not the only factor; a better COVID-19 management and the less severity of newer variants may have played a significant role as well. Previous reports suggest that COVID-19 management (eg, steroids, antivirals, monoclonal antibodies) have also impacted outcomes.

In conclusion, with the caution derived from the limited patient number and the intrinsic nature of this study, our data show favorable clinical presentation and outcome of breakthrough SARS-CoV-2 infections in HM who previously received a fourth dose of anti-SARS-CoV-2 vaccine. These data suggest that a second vaccine booster may be of particular importance to protect this particularly vulnerable patient population from severe or potentially life-threatening COVID-19.

ACKNOWLEDGMENTS

The authors thank all contributors for their utmost contributions and support to the project during a pandemic situation.

AUTHOR CONTRIBUTIONS

LP served as the principal investigator. JS-G, FM, and LP contributed to study design, study supervision, and data interpretation and wrote the paper. JS-G, FM, and LP did the statistical plan, analysis and interpreted the data. All the authors recruited participants and collected and interpreted data. All authors contributed to manuscript writing and review of the manuscript. All authors agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

DISCLOSURES

PC is a HemaSphere Editor. The authors have no conflicts of interest to disclose.

SOURCES OF FUNDING

EPICOVIDEHA has received funds from Optics COMMITTM (COVID-19 Unmet Medical Needs and Associated Research Extension) COVID-19 RFP program by GILEAD Science, United States (Project 2020–8223). The funder of the study had no role in study design, data analysis, interpretation, or writing of the report. All authors had full access to the data and had final responsibility for the decision to submit for publication.

REFERENCES

1. Pagano L, Salmanton-García J, Marchesi F, et al. COVID-19 infection in adult patients with hematological malignancies: a European Hematology Association Survey (EPICOVIDEHA). J Hematol Oncol. 2021;14:168.
2. Cesarò S, Ljungman P, Mikulska M, et al. Recommendations for the management of COVID-19 in patients with haematological malignancies or haematopoietic cell transplantation, from the 2021 European Conference of Infections in Leukaemia (ECIL-9). Leukemia. 2022;36:1467–1480.
3. Pagano L, Salmanton-García J, Marchesi F, et al. COVID-19 in vaccinated adult patients with hematological malignancies: preliminary results from EPICOVIDEHA. Blood. 2022;139:1588–1592.

4. Christensen PA, Olsen RJ, Long SW, et al. Signals of significantly increased vaccine breakthrough, decreased hospitalization rates, and less severe disease in patients with coronavirus disease 2019 caused by the Omicron variant of severe acute respiratory syndrome coronavirus 2 in Houston, Texas. Am J Pathol. 2022; 192: 642–652.

5. Bar-On YM, Goldberg Y, Mandel M, et al. Protection by a fourth dose of BNT162b2 against Omicron in Israel. N Engl J Med. 2022;386:1712–1720.

6. Arbel R, Sergienko R, Friger M, et al. Effectiveness of a second BNT162b2 booster vaccine against hospitalization and death from COVID-19 in adults aged over 60 years. Nat Med. 2022;28:1486–1490.

7. European Centre for Disease Prevention and Control. COVID-19: Joint statement from ECDC and EMA on the administration of a fourth dose of mRNA vaccines (europa.eu). Available at: https://www.ecdc.europa.eu/en/news-events/ema-ecdc-statement-fourth-covid-vaccine-dose. Accessed June 18, 2022.

8. Piechotta V, Mellinghoff SC, Hirsch C, et al. Effectiveness, immunogenicity, and safety of COVID-19 vaccines for individuals with hematological malignancies: a systematic review. Blood Cancer J. 2022;12:86.

9. Salmanton-García J, Busca A, Cornely OA, et al. EPICOVIDEHA: a ready to use platform for epidemiological studies in hematological patients with COVID-19. HemaSphere. 2021;5:e612.

10. Blennow O, Salmanton-García J, Nowak P, et al. Outcome of infection with omicron SARS-CoV-2 variant in patients with hematological malignancies: An EPICOVIDEHA survey report. Am J Hematol. 2022;97:E312–E317.

11. Langerbeins P, Hallek M. COVID-19 in patients with hematologic malignancy. Blood. 2022;140:236–252.

12. Mittelman M. Is COVID-19 vaccine effective in patients with myeloid malignancies? Br J Haematol 2022; 197: 656–658.