

11th
EUROPEAN
CONFERENCE on
INFECTIONS in
LEUKAEMIA



Vaccination guidelines
UPDATE

Part I: HCT

Slide set for public consultation, Sept. 25, 2026

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From September
17th to 19th, 2026

The ECIL 11 Vaccine Group

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*Members of the previous, ECIL7, vaccine group September 17th to 19th, 2026

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Objectives of the Vaccine Group for ECIL 11

1 - to **update the previous** (*ECIL 7; Cordonnier et al. LID 2019*)
HCT vaccine guidelines, due to recent data which were not available at ECIL 7 (rHZ vaccine, RSV vaccines...)

Part I

2 - to **update the previous COVID vaccine guidelines**
(*ECIL 10; Cesaro et al. Leukaemia 2025*)

3 - to **develop guidelines for CAR-T cell and bispecific recipients**

Part II

Limit the review to vaccines available in Europe, and to english literature

Abstracts considered as provisional data

Grading

Category, grade		Definition
Strength of recommendation	A	Strongly supports a recommendation for use
	B	Moderate evidence to support a recommendation for use
	C	Poor evidence to support a recommendation
	D	Supports a recommendation against use
Quality of evidence—Level	I	Evidence from ≥ 1 properly randomized controlled trial
	II	Evidence from ≥ 1 well-designed clinical trial, without randomization; from cohort or case-controlled analytic studies (preferably from > 1 centre); from multiple time series; or from dramatic results from uncontrolled experiments
	III	Evidence from opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees
Quality of evidence—Index (for Level II)	r	Meta-analysis or systematic review of RCT
	t	Transferred evidence, that is, results from different patients' cohorts, or similar immune-status situation
	h	Comparator group is a historical control
	u	Uncontrolled trial
	a	Published abstract (presented at an international symposium or meeting)

Ullmann AJ et al. ESCMID* guideline for the diagnosis and management of Candida diseases 2012: developing European guidelines in clinical microbiology and infectious diseases. Clin Microbiol Infect 2012; 18 (Suppl. 7): 1–8

Part I

Guidelines update in HCT recipients

Vaccines not addressed, due to the lack of new, pertinent data: HiB, Tetanus, Diphtheria, Pertussis, Poliomyelitis, MMR, Varicella

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Pneumococcal vaccination after HCT

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Most recent conjugate pneumococcal vaccines available in Europe and EMA indications

Vaccine	Year of 1st licence	Indication in children	Indication in adults	Data in HCT recipients	Data in other immunocompromised pt populations
PCV15 (V114) Vaxneuvance ® <i>Merck</i>	2021	Yes ≥ 6 weeks	Yes	Yes	Sickle-cell disease/children HIV/children/adults
PCV20 Prevenar 20 ® <i>Pfizer</i>	2022	Yes ≥ 6 weeks	Yes	No (except 10 autologous Pts*)	No
PCV21 (V116) Capvaxive ® <i>Merck</i>	2025	Yes 2-18y	Yes	No	HIV (n=313)

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* Gung C, Abstract. Transplantation and Cellular Therapy 312S(2025) S363-S383

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Summary of the selected prospective and retrospective studies on pneumococcal vaccination in HCT recipients

Main new data in Allo and with PCV13 or PCV15. After allogeneic HCT, PCV15 provides a comparable response to PCV13 on the common serotypes and additionally induces a response to the 2 PCV15-specific serotypes (22F and 33F). No safety concern (*Wilck et al. CID 2023*)

No data with PCV20 except one abstract with 10 myeloma pts vaccinated after autoHCT (*Gung C, TCT 2026*).

No data with PCV21

One study shows no benefit of a 4th dose (vs 3) of PCV in allogeneic HCT recipients *without GvHD or steroids* at baseline when assessed after an additional PSV23 dose (*Okinaka K et al. CMI 2023*). However, such benefit has been shown in previous studies in patients *with and without GvHD* (*Garcia-Garrido AJH 2021; Cordonnier CID 2015*)

Retrospective studies confirm the high response rates to PCVs, the great variability of the response according to the serotypes and the poor response to PSV23

Maintenance treatment after autoHCT in myeloma seems to have no impact on the vaccine response

⇒ **No new data challenges the ECIL 7 recommendations on the timing and number of doses for the initial program (3 doses of PCV from 3 months after transplant)**

The availability of PCV20 considerably decreases the benefit of PSV23

Pneumococcal vaccination

ECIL 11 guidelines for ALLOGENEIC ADULT HCT recipients (1/6)

From 3 months after transplant: 3 doses of PCV at 1 month interval

AI

Among the available PCVs, the physician should choose the one with the broader serotype-spectrum between **PCV13, PCV15**

BI

and PCV 20

AIIt

and in accordance with the country-specific epidemiology



Pneumococcal vaccination

ECIL 11 guidelines for ALLOGENEIC ADULT HCT recipients (2/6)

At 12 months:

An additional dose of pneumococcal vaccine should be administered **BI**

If the initial vaccination was done with PCV13, 15 or 20, an additional dose of PCV20 or PCV21 should be administered if available **BIIt**

If neither PCV20 nor 21 is available, an additional dose of either PCV13 or 15 (in case of GvHD) or PSV23 (if no GvHD) should be administered **BIlu**

In terms of serotype coverage, the combination of PCV20 followed by PCV21 offers the larger spectrum



Pneumococcal vaccination

ECIL11 guidelines for AUTOLOGOUS ADULT HCT recipients (4/6)

From 3 months after transplant

- 3 doses of PCV at 1 month interval

BIIt

with the broader serotype-spectrum between PCV13, PCV15 and PCV20, and according to the country-specific epidemiology

BIIt

At 12 months after transplant:

- An additional dose should be administered

CIIt

- either with PCV20 or PCV21 when available

- or with PSV23 if the initial vaccination program was done with PCV13 or PCV15, and PCV20 or PCV21 is not available

CIIt

In terms of vaccine coverage, the combination of PCV20 followed by PCV21 offers the larger spectrum

Maintenance therapy with lenalinomide does not impact the response and should not postpone vaccination

Pneumococcal vaccination

ECIL11 guidelines for the management of long-term vaccination program (≥ 24 months after HCT) (5/6)

Due to the progressive decline of antipneumococcal antibodies over time, **a boost of PCV20 or PCV 21 can be considered from 2-3 years after HCT**, especially in patients who have been vaccinated early (3-6 mo.) or at a time of active GVHD, those who have received a cord-blood transplant, have relapsed of the underlying disease or have persistent cGvHD

CIII

For centers which have the possibility to assess Ab titers to the vaccine serotypes, this assessment may help in defining the best option at a given time for a patient

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Pneumococcal vaccination Pediatric specificities (6/6)

ECIL11:
No change

- Pediatric patients respond better than adults
- Their responses are close to those of healthy children (*Meisel et al. Blood 2007*)
- More post-vaccine fever, more local reactions than adults
- **Same schedule recommended for children and adults.**

The choice of the PCV should be consistent with the country recommendations according to the age of the patient and the serotype distribution

Meningococcal vaccination after HCT

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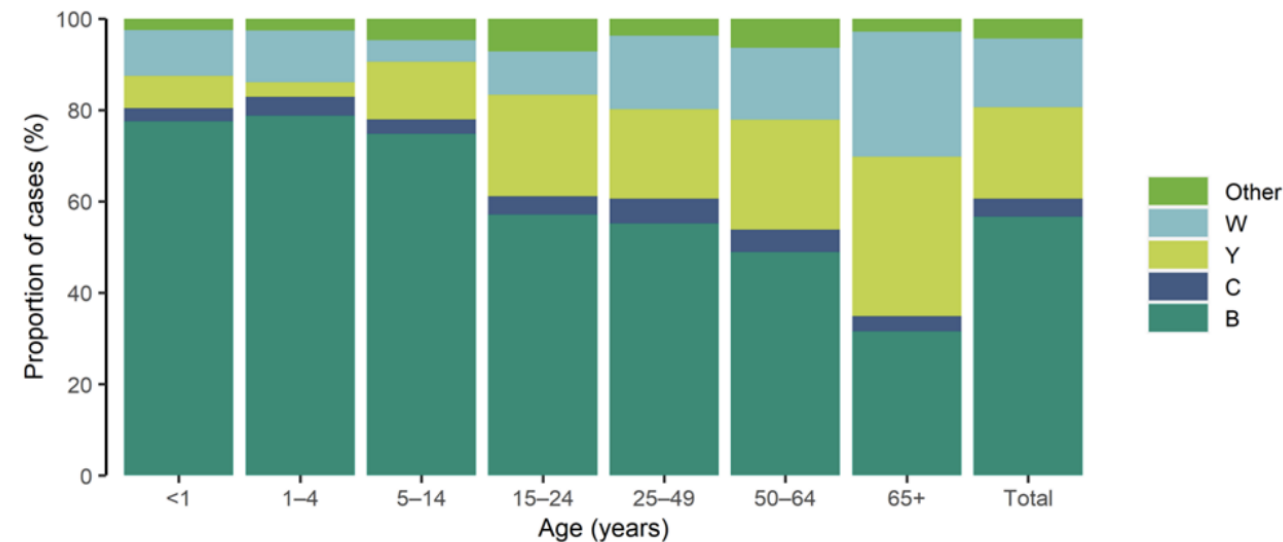
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Epidemiology of Invasive Meningococcal Disease (IMD) in Europe

- In 2023, 1895 confirmed cases of IMD, including 200 deaths, were reported in 30 European countries.
- France, Germany and Spain accounted for 57% of all confirmed IMD cases.
- The notification rate of IMD rose to 0.4 cases per 100 000 population, which is the highest since 2020.
- Higher rates in infants ≤ 1 year old, followed by 1–4-year-olds and 15–24-year-olds.
- **Serogroup B remains the major cause of IMD (57% of cases with known serogroup)** and was dominant in all age groups under 65 years. Its notification rate has been increasing since 2021.
- **Serogroup Y** was the second most reported overall (20% of cases with known serogroup) and the most reported in those ≥ 65 years old.
- **Serogroup W** was the third most reported overall (15% of cases with known serogroup)

Figure 5. Serogroup distribution of confirmed cases of invasive meningococcal disease by age group, EU/EEA, 2023



'Other' refers to all cases reported as serogroups A, X, Z or 29E; non-groupable; or 'other'.

<https://www.ecdc.europa.eu/sites/default/files/documents/invasive-meningococcal-disease-annual-epidemiological-report-2023.pdf>

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ECIL 11 recommendations for meningococcal vaccination

Adult allogeneic Transplant

- In countries with a national pediatric immunization program, meningococcal vaccination is recommended from 6 months after transplant **B IIu**
- Whether there is a national pediatric immunization program or not, HCT recipients with additional risk factors for IMD, such as splenectomy, functional asplenia, or eculizumab treatment, should receive a full meningococcal vaccine schedule post-transplant **BIIu**
- In outbreak settings, vaccination should be administered in line with local guidance
- At least two doses each of Men B vaccine and MenACWY vaccines should be administered **B IIu**
Where MenACWY is not available, MenC vaccine should be used
- Booster doses should be administered in line with individual country recommendations for a given age and/or ongoing additional risk factors including students living in campus accommodation, those travelling to high-incidence areas, soldiers, and those undertaking the Hajj pilgrimage.

Adult autologous Transplant

- Same recommendation as for allogeneic transplant, though **B II^t** for the Men B vaccine

Paediatric Same recommendation than for adults

BII^t

Vaccination with the recombinant Zoster Vaccine (rZV) after HCT

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The recombinant Zoster Vaccine (rZV; Shingrix®)

Recombinant vaccine targeting the VZV glycoprotein E antigen (gE) and containing the adjuvant AS01B

- Licensed in Europe for:
 - ≥ 50 years in non-immunocompromised patients (2017)
 - ≥ 18 years in immunocompromised patients (2020)

Vaccine efficacy against zoster:

- non-IC pts ≥ 50 years: 97.2% (*Lal H et al. NEJM 2015*)
- non-IC pts ≥ 70 years: 91.3% (*Cunningham AL et al. NEJM 2016*)
- ≥ 18 years with non-transplanted hematologic malignancies (Zoster 039): 87% (*Dagneu AF et al. LID 2019*)

In non –immunocompromised individuals, rZV remained significantly protective **11 years** after the initial 2-dose vaccination (*Strezova A et al. @ClinMed 2025*)



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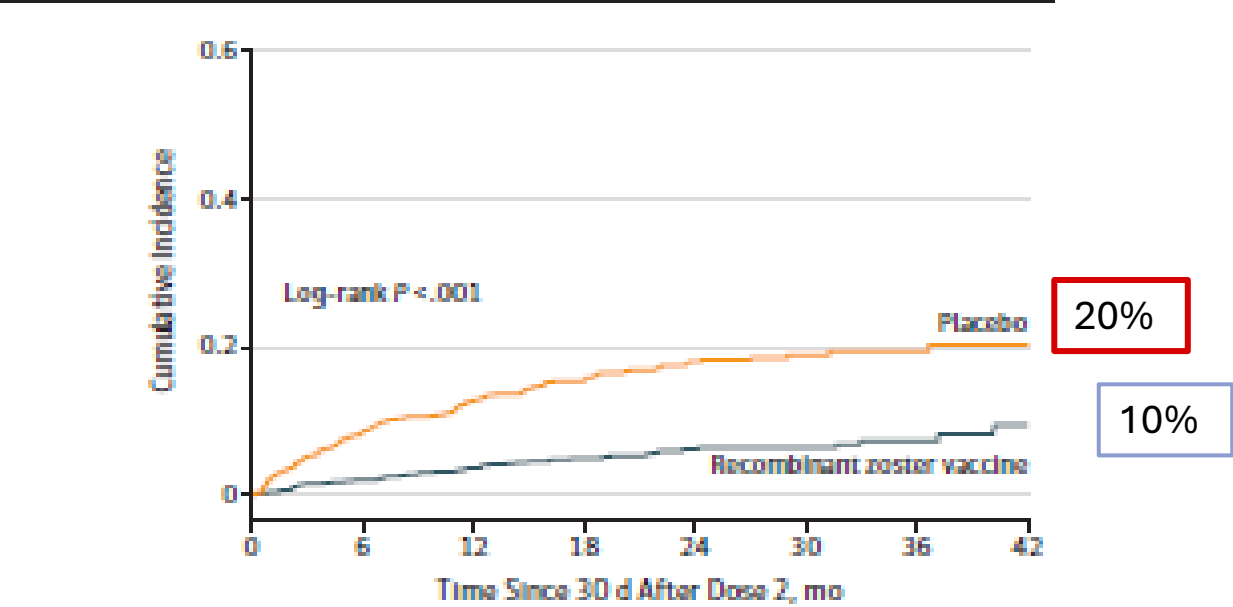
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Effect of Recombinant Zoster Vaccine on Incidence of Herpes Zoster After Autologous Stem Cell Transplantation

A Randomized Clinical Trial

Adriana Bastidas, MD; Javier de la Serna, MD; Mohamed El Idrissi, MSc; Lidia Oostvogels, MD; Philippe Quittet, MD; Javier López-Jiménez, MD, PhD; Filiz Vural, MD; David Pohlreich, MD; Tsila Zuckerman, MD; Nicolas C. Issa, MD; Gianluca Gaidano, MD, PhD; Je-Jung Lee, MD; Sunil Abhyankar, MD; Carlos Solano, MD, PhD; Jaime Perez de Oteyza, MD, PhD; Michael J. Satlin, MD; Stefan Schwartz, MD; Magda Campins, MD, PhD; Alberto Rocci, MD, PhD; Carlos Vallejo Llamas, MD, PhD; Dong-Gun Lee, MD, PhD; Sen Mui Tan, MD; Anna M. Johnston, MBBS; Andrew Grigg, MBBS, FRACP, MD; Michael J. Boeckh, MD, PhD; Laura Campora, MD; Marta Lopez-Fauqued, PhD; Thomas C. Heineman, MD, PhD; Edward A. Stadtmauer, MD; Keith M. Sullivan, MD; for the ZOE-HSCT Study Group Collaborators

Figure 2. Cumulative Incidence of Herpes Zoster Overall (Modified Total Vaccinated Cohort)



No. at risk								
Placebo	851	704	604	464	337	209	112	40
Recombinant zoster vaccine	870	779	682	537	396	268	141	49
No. with ≥1 herpes zoster episode								
Placebo	0	69	100	117	130	133	134	135
Recombinant zoster vaccine	0	17	30	38	44	45	47	49

2 vaccine doses, 1-2 months apart.
1st dose between days 50-70 after HCT

Primary outcome :
occurrence of confirmed HZ cases between 1st dose and study end.

Zoster:
30 vs. 94 cases for 1 000 p/y
=> Vaccine efficacy: 68%

ECIL11 guidelines for herpes zoster vaccination after AUTOLOGOUS HCT in adults

- Val/acyclovir is highly protective against Zoster
- Vaccination with the recombinant Zoster Vaccine is recommended for adult autologous HCT recipients, with 2 doses at 2 months interval, irrespectively of post-transplant VZV serology and of previous pre- or post-transplant HZ episode(s) **AI**
- The best time to start vaccination is not determined and should be individually adapted according to the planned duration of val/acyclovir and immunosuppression but should not start before 2 months after transplant
- In patients receiving IS maintenance after auto and/or pts with prolonged ACV, the vaccination is recommended to be delayed * **BIIt**
- Val/acyclovir prophylaxis should be maintained at least one 1 month after the 2nd dose

** Lenalidomide is not considered as immunosuppressive for vaccination*

Summary of the 3 prospective studies on rZV in allogeneic HCT recipients (total no. pts: 281)

- No study with non-vaccinated controls, no proof of clinical efficacy
- No major safety concern (*Baumrin E et al. Blood advances 2021*)
- Most patients received antiviral prophylaxis for several months after vaccination
- Two of the 3 studies do not give any data on the incidence of zoster after rZV
- In two small-size series, pts vaccinated at a median of 22-37 mo. after transplant with 2 doses elicited a gE-specific IFN γ -ELISpot response in 56-91% and an anti-gE Ab response in 75%, with **no correlation between cellular and humoral response** (*Koldehoff Vaccine 2022; Konuma, J Infect Chemoth 2025*)
- However, around 45% of these pts had experienced zoster before rZV vaccination and the responses were better after zoster+rZV than after rZV alone in this subpopulation (*Koldehoff M et al. Vaccines 2022; Konuma T et al. J Infect Chemother 2025*)



Summary of the 6 retrospective studies on rZV in ALLOgeneic HCT recipients (total no. pts: 535)

- The pts were mostly vaccinated after 12 months and often several years after transplant
- One study comparing the prevalence of zoster after rZV to the one of an historical non-vaccinated group showed a significant reduction of the incidence of zoster from 19.7% to 5.9% at 2 years after transplant. In this study, antiviral prophylaxis was as protective as the vaccine (*Lee R et al. Transpl Cell Ther 2025*)
- Another study did not find any difference of prevalence overall between vaccinated and not-vaccinated patients but suggested a benefit of rZV on incidence of zoster only when given after 12 months post-transplant (*Hall VG et al. Transplant Cell Ther 2026*)

Most retrospective studies suffer from imprecisions on duration of antiviral prophylaxis after rZV, on duration of follow-up and on the rationale to vaccinate some patients and not other ones during the same period of time, making difficult to estimate the vaccine efficacy



ECIL11 guidelines for herpes zoster vaccination after ALLOGENEIC HCT in adults

- Val/acyclovir is highly protective from HZ reactivation and its duration should not be shortened by vaccination when needed
- Vaccination with rZV (2 doses at 2 months interval) may be considered after allogeneic HCT in patients without GvHD and/or IS

BII hu

- Vaccination should preferably start from 12 months after transplant and before stopping val/acyclovir

BIIu

- Val/acyclovir prophylaxis should be maintained at least one 1 month after the 2nd dose.



Pediatric specificities

- The vaccine is not approved in children
- There is no experience with the rZV in transplanted children
- rZV therefore is not recommended
- Prospective studies are required

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Human papilloma virus (HPV) vaccination after HCT

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Human papilloma virus (HPV)

What's new ECIL 7 on HPV and HCT?

- EMA extension of the indication to male adolescents (> 9 y) from 2019
- EMA indication « from 9 y » but most European countries limit the recommendation to 9-26 y
- **FDA indication 2018: extension to female patients till $\leq$ 45 years**
- More epidemiology data highlighting the risk of HCT for HPV-induced premalignant and malignant oral and genital lesions in **allogeneic** HCT recipients, especially with **cGvHD**
(Shanis D, BMT 2018; Zhao H, TCT 2021)
- 5 year update of a previous study in adolescents (MacIntyre CR, Vaccine 2019)
- **New vaccine data in female patients 18-49 y** (Stratton P, JAMA Oncol 2020) **and adolescents**
(Landier W, Lancet Child Adolesc Health 2022)



ECIL 11 guidelines for HPV-vaccination in HCT-recipients

HPV vaccination is recommended for adolescents and young adults (**male and female**) at the age-ranges recommended by national guidelines, starting 6-12 months after transplant, both in auto- and allogeneic transplant recipients

BIu

HPV vaccination should be given using the highest-valency vaccine available (currently the 9-valent vaccine) as a three-dose schedule

BIIt

HPV vaccination can be considered for female (**BIu**) and male (**CIIt**) recipients of allogeneic HCT > 25 years old, especially in case of chronic GvHD

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Hepatitis B virus (HBV) vaccination after HCT

Previous ECIL guidelines for HBV hepatitis: ECIL 5 (Mallet et al. LID 2016); ECIL 7 (Cordonnier et al, LID 2019; ECIL 9 (Mikulska et al. Lancet Haematol 2025)

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Heplisav-B Summary

- Better efficacy than Engerix B 20µg well demonstrated in non-immunocompromised patient populations, patients on chronic hemodialysis, and HIV+ patients, 1st and 2nd line
- Few data in other immunocompromised patient. **No data in HCT recipients or CAR-T or bispecifics recipients**

Expected benefits of Heplisav-B vs. 2nd generation vaccines:

- better seroprotection rates and antiHBs titers
- shorter vaccine schedule and less doses (2 doses, 1 month apart)
- better response in patients who failed after a 2nd generation vaccine series

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2025

EASL Clinical Practice Guidelines on the management of hepatitis B virus infection[☆]

European Association for the Study of the Liver^{*}

Recommendation

- For immunosuppressed or immunodeficient individuals, including patients with cirrhosis or those on haemodialysis, an increased dose of standard (or second-generation) vaccines (double dose or dose tailored for patients on dialysis) or third-generation vaccines should be administered (**LoE 1, strong recommendation, strong consensus**).

The ECIL 11 panel endorses the EASL recommendation (no grading)

However, until now in Europe, the vaccine is commercialized only in Germany

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Covid-19 vaccination after HCT

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Suggested COVID 19 vaccine schedule for HCT patients, ECIL 11 (proposal)

Time from HCT	Immune status considerations	Action	Vaccine type (EMA approved)	Notes
0 - < 3 months	Profound immunosuppression Poor vaccine response expected	Defer vaccination	Not applicable	Vaccinate if exceptional circumstances (e.g., outbreak exposure) and after specialist evaluation
3 - 6 months	Early immune reconstitution, but response still suboptimal	Start primary vaccination series if the patient is considered at high risk for COVID-19	mRNA preferred: Comirnaty (Pfizer-BioNTech), Spikevax (Moderna)	To prefer this window if : Stable engraftment No severe GVHD No intense immunosuppression High community transmission
> 6 months	Improved B-cell and T-cell recovery	Start (or continue) 3-dose primary series	mRNA preferred; protein-based (Nuvaxovid, Bimervax, Kostaive) acceptable if mRNA contraindicated	To prefer this window if: Poor engraftment before 6 mo. severe GVHD intense immunosuppression (before 6 mo.)
After completion of primary series	Ongoing immunosuppression or GVHD may blunt response	1 updated booster dose (variant-adapted)	As above	Give booster ≥ 3 months after last dose
Long-term (annual/seasonal)	If Immune recovery is incomplete, the risk remains elevated	Annual updated COVID-19 vaccine (as influenza model)	All EMA-approved updated vaccines	

No difference of vaccine doses or antigen concentration between immunocompetent and immunocompromised subjects

Change of grading or statement	COVID 19 Vaccination Recommendations for HCT patients	ECIL 10	ECIL 11
Minimal change	HCT recipients should receive a primary schedule (3 doses) of COVID-19 vaccine	Allu	Allu
Minimal change	Timing of vaccination should be based on individual consideration taking into account the immune status of the patient and the prevalence of SARS-CoV-2 in the community but no earlier than 3 months after cell infusion	BIlu	BIlu
Minimal change	For mRNA vaccines, the interval between the first two doses should be at least 3 weeks* and the interval between the 2 nd /3rd dose should preferably be 3 months**	Alltu	All tu
Minimal change	If indicated, additional (booster) dose(s) of SARS-CoV-2 vaccine should be given after at least 3 months from the 3rd dose according to the country recommendations***	Alltu	All tu
Minimal change	HCT patient, vaccinated with a full program including those having had SARS-CoV-2 infection, should receive at least yearly booster doses with an updated vaccine according to country recommendations	Alltu	All tu
Minimal change	In preparation of the winter season the co-administration at the same day of COVID-19 vaccine booster dose with influenza, according to the age-appropriate doses for children, adolescents, and adults is recommended	BIIt	BIl t
Minimal change	For patients having verified SARS-CoV-2 infection, booster dose(s) should be delayed at a minimum of 3 - 4 months after the resolution of the episode.	Alltu	All tu

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* 4 weeks CDC/NMDP/ECDC-EMA. ** ≥ 4 weeks in CDC/ECDC-EMA, ≥ 8 weeks NMDP. *** CDC/ECDC-EMA: 6 months, minimum 2 months

Change of grading or statement	COVID 19 Vaccination Recommendations for HCT patients	ECIL 10	ECIL 11
Minimal change	Primary COVID-19 vaccination and booster administration are recommended in HCT children, starting from 6 months of age, with the product and dosage approved for age	Alltu	Alltu
No change	In the absence of well-established criteria for protection, it is not recommended to assess anti-SARS-CoV-2 antibody titers nor T-cell response with the aim to determine the need for booster doses.	DIIIt	DIIIt
No change	HCT patients should be informed of the ongoing risk of SARS-Cov-2 infection despite vaccination and follow the hygiene and social distancing recommendations of their community or country.	BIIt	BIIt
Minimal change	Vaccination of health care personnel and of household contacts of HCT patients, in accordance with regulatory authority approval and national recommendations for specific age groups, is recommended.	BIIt	BIIt
No change	Prophylaxis with MoAbs directed to SARS-CoV-2 should not prevent vaccination against COVID-19 in situations where such are indicated	BIII	BIII
New	Although a mild risk of HZ infection has been reported in immunocompetent individuals receiving ≥ 3 COVID-19 vaccine doses/booster, no specific data are available for HCT patients		No grading
Changed	Although COVID-19 vaccination can trigger a flare or an onset of graft-versus-host disease (GVHD) in allogeneic HCT recipients, mild-moderate GVHD should not be a contraindication to vaccination	CII	BIlu



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Influenza vaccination after HCT

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Allo-HCT

Studies examining 1 vs 2 doses

Benefit of 2 doses:

- Linnik *et al* JID 2022 (Observational)
 - 2 doses required to achieve comparable immunogenicity to Health Controls (135 HCT and 69 healthy volunteers).
- Vidya *et al* Transplant Immunology 2025 (Meta-analysis)
 - Improved immunogenicity after 2nd dose of HD vaccine (402 patients).

No benefit of 2 doses:

- Zhang *et al* Clinical Translational Immunology 2023 (Observational)
 - (n=8 assessed after 2 doses) very modest increase in HAI titres in previous non-responders

Studies examining High Dose vs Standard Dose

Favours High Dose:

- Vidya *et al* Transplant Immunology 2025 (Meta-analysis)
 - Increased immunogenicity but no demonstrable effectiveness improvement
- LD Thomas *et al* CID 2023 (Phase 2 RCT)
 - >70% seroprotection from HD (2-doses).
 - SD group (2-doses) didn't meet criteria for seroprotection (64 received SD-QIV and 60 received HD-TIV).

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AutoHCT

- Teh *et al* CID 2021 (RCT)
 - Comparing HD-SD and SD-SD 2-dose regimens
 - No difference in seroprotection/seroconversion rates
 - Seroprotection following dose 2 of 75-88.2% for Influenza A strains, and 78.8-97.1% for Influenza B strains

Paediatric

Schuster *et al* RCT NEJM 2023, CID 2024 (RCT)

- Improved immunogenicity with 2 doses of HD-TIV versus 2-doses of SD-QIV.
- Seroconversion criteria not met in either group after 1 dose.

Ryan AL *et al* Bone Marrow Transplant 2020

- For children in the HSCT group who received two doses of the vaccine and seroconverted, a second dose of the vaccine was required for seroconversion in 47% for H3N2, 70% to H1N1 and 81% to B strain



ECIL 11 Proposed Influenza Recommendations for Allo HCT

Annual seasonal IIV is recommended for all patients (**A II r**).

Vaccine Timing:

- Vaccination should be considered at the start of influenza season for all patients at 3 months post-transplant. Vaccination from 6 months post-transplant is associated with better response. Blunted responses may be expected in those vaccinated <6 months post-transplant, or in active GVHD (**B II r**).
- A two-dose schedule of IIV administered four weeks apart can be considered in selected recipients with a low likelihood of adequate humoral response, such as those vaccinated earlier than 6 months post-transplant or those with active GvHD and/or on immunosuppressive drugs, in accordance with local policies and public health recommendations (**A II r**).

Vaccine Choice:

- High-dose trivalent IIV targeting influenza virus A and B is preferred when available for patients undergoing allo-HCT (**A II r**).
- Adjuvanted influenza vaccine is likely to be more immunogenic than standard dose IIV in the case that high-dose vaccine is not available (**B II t**)
- All patients should continue to receive age-appropriate annual influenza vaccination thereafter in line with national policy



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ECIL 11 Proposed Influenza Recommendations for Auto HCT

Annual seasonal IIV is recommended for all patients **(A II r)**

Vaccine Timing:

- Vaccination should start from 3 months post-transplant **(B II r)**.
- Two doses of IIV should be administered 4 weeks apart in the first influenza season post-transplant. One dose at the beginning of influenza season should be administered thereafter for at least as long as the patient is judged to be immunocompromised **(B II r)**.

Vaccine Choice:

- For those <65 years, a standard is recommended **(A II u)**.
- Those aged ≥65 years should receive a high-dose formulation where available, as high-dose vaccination has been shown to have superior effectiveness in this age-group **(A II t)**.

ECIL 11 Proposed Influenza Recommendations for children after HCT

Annual seasonal IIV is recommended for all patients **(A II r)**.

Vaccine Timing:

- Vaccination should be considered at the start of influenza season for all patients at 3 months post-transplant. Vaccination from 6 months post-transplant is associated with better response. Blunted responses may be expected in those vaccinated <6 months post-transplant, or in active GVHD **(B II t)**.

Vaccine Choice:

- Children aged 6 months up to 18 years receiving IIV for the first time after transplantation should receive a second dose at least 4 weeks after the first dose **(A II u)**
- All patients should continue to receive age-appropriate annual influenza vaccination thereafter in line with national policy
- LAIV is not recommended in children who have received a stem cell transplant or with ongoing immunosuppression **(D)**.

Respiratory Syncytial virus (RSV) vaccination after HCT

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Background

- 3 Vaccines licensed in Europe since 2023 based on pivotal studies performed in immunocompetent participants
- Several international bodies have incorporated recommendations for RSV vaccination in immunocompromised hosts

Arexvy (GSK)	Abrysvo (Pfizer)	mResvia (Moderna)
AS01 _E adjuvanted RSVPreF3	Bivalent recombinant PreF vaccine	mRNA encoding RSV-A glycoproteinF
Adults aged ≥18 years (updated January 2026)	Adults aged ≥ 18 years Pregnant women	Adults aged ≥60 years Adults aged 18-59 years at increased risk of RSV-associated LRTI

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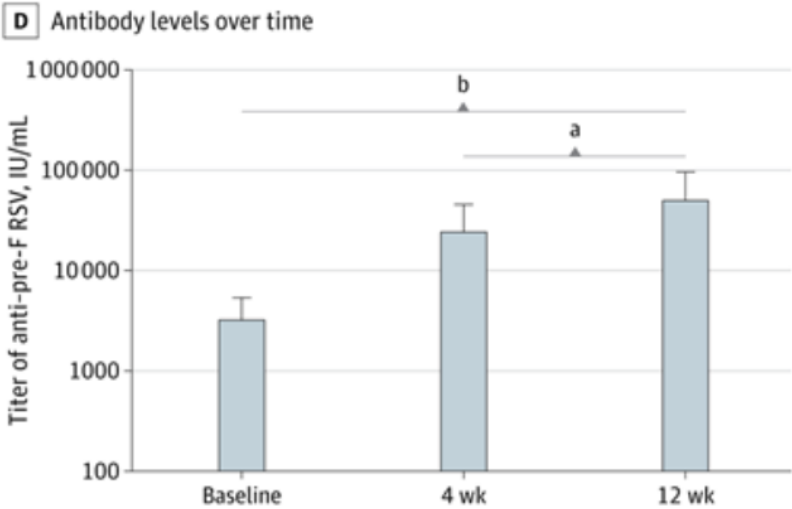
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3 studies examining RSV vaccines in HCT

Study		Vaccine	Age	Time from HCT	Humoral Response	T-cell Response	Comments
Redjoul <i>et al</i> JAMA 2025	n=92	Abrysvo	Median age 63 (IQR 53-70)	3-6 months 18 (20%) 7-12 months 14 (15%) >12 months 60 (65%)	Seroconversion (≥ 4 -fold rise anti-PreF IgG) ~52% at 4 weeks; 75% ≥ 1 year post-transplant, 9% <1 year	NA	Potential role for extra dose in non-responders (3 of 8 revaccinated had titre increase)

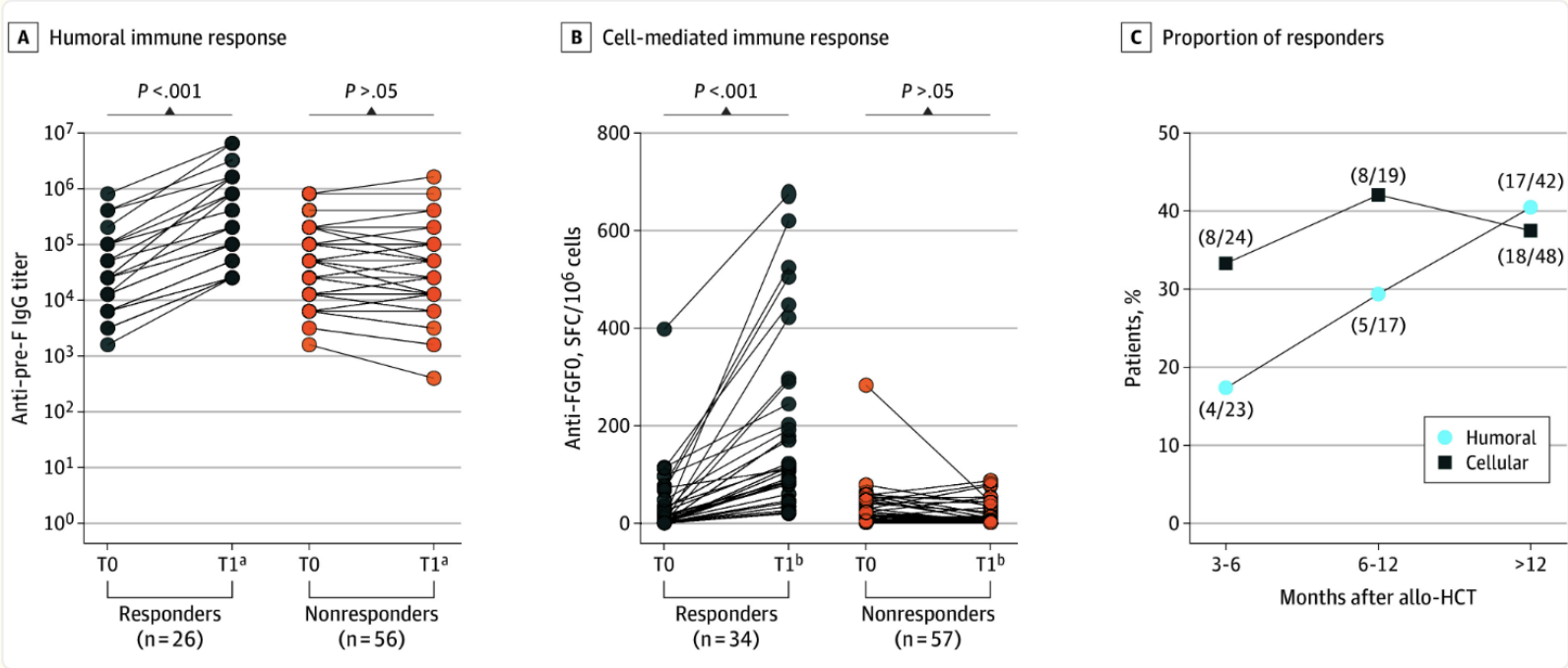


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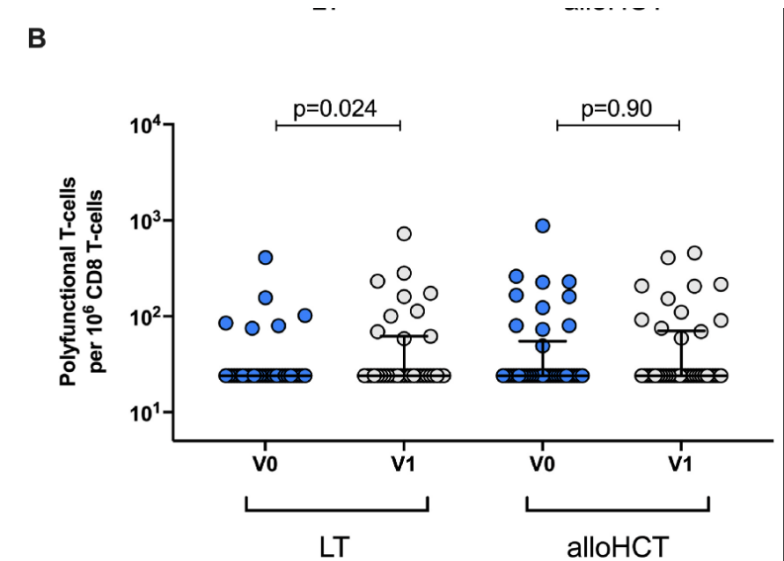
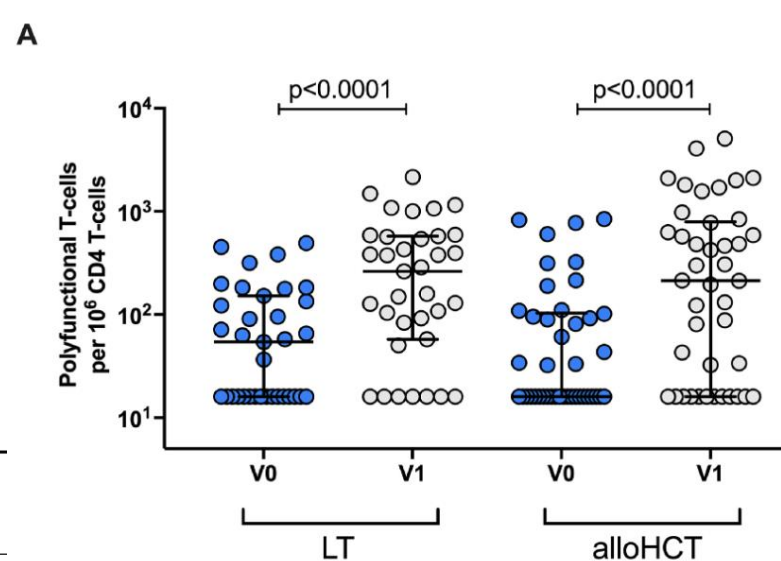
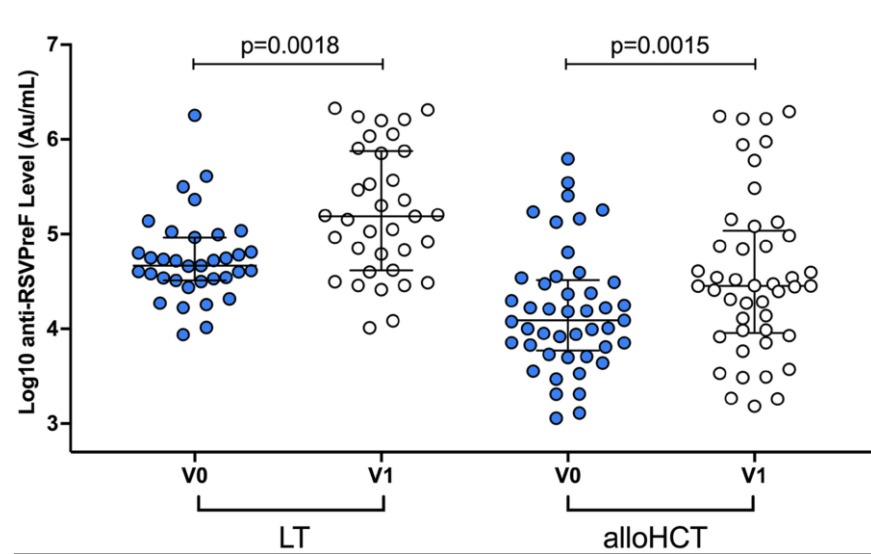


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Study		Vaccine	Age	Time from HCT	Humoral Response	T-cell Response	Comments
Lotscher <i>et al</i> JAMA 2025	n=94	Arexvy	Median age 64 (IQR~57-71)	26 patients (27.7%) 3-6 months, 20 (21.3%) 6-12 months, 48 (51.1%) >12 months post allo- HCT.	Humoral responders (defined ≥ 4 -fold rise anti-PreF IgG) ~32% overall; better >12 months post-HCT.	CMI response: IFN γ ELISpot, (≥ 5 -fold increase with ≥ 20 or >100 SFCs.) CMI responders ~37% increases in responders. CMI responses didn't increase with time from transplant.	Strong influence of immune reconstitution time from transplant, IVIg, ongoing therapy.



Study		Vaccine	Age	Time from HCT	Humoral Response	T-cell Response	Comments
Hall <i>et al</i> CMI 2026	n=45	Arexvy	Median age 64 (IQR 59-69)	Median 18.5 (10–30.5)	Seroconversion (≥ 4 -fold increase in NT95 from baseline): 33% in alloHCT	Significant increase in polyfunctional CD4 post-vax, not CD8; polyfunctional CD4 correlation with PreF IgG levels	Supports feasibility + immunogenicity, but not protection magnitude.



- Lack control groups
- Vaccine efficacy and effectiveness not powered/studied
- Mortality benefit and RR hospitalisation unknown

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Vaccine Effectiveness

- **VE 29.4%-44.4% in HSCT** recipients against ARI in those aged 60 and above (lowest of all groups including SOT)
 - *Fry et al JAMA 2025*
- 58.92% (95% CI 44.3, 69.36) at 12 months, and 39.74% (23.88, 52.67) against documented RSV infection in “immunocompromised”
 - *Bejama et al JAMA 2025*
- VE of 54% (95% CI, –2% to 79%) among “immunocompromised patients”, lower again for a second season
 - *Surie et al JAMA 2025*
- Vaccine effectiveness against hospitalisation of 69% in immunocompromised
 - *Sumsuzzman et al CID 2026*

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Booster doses

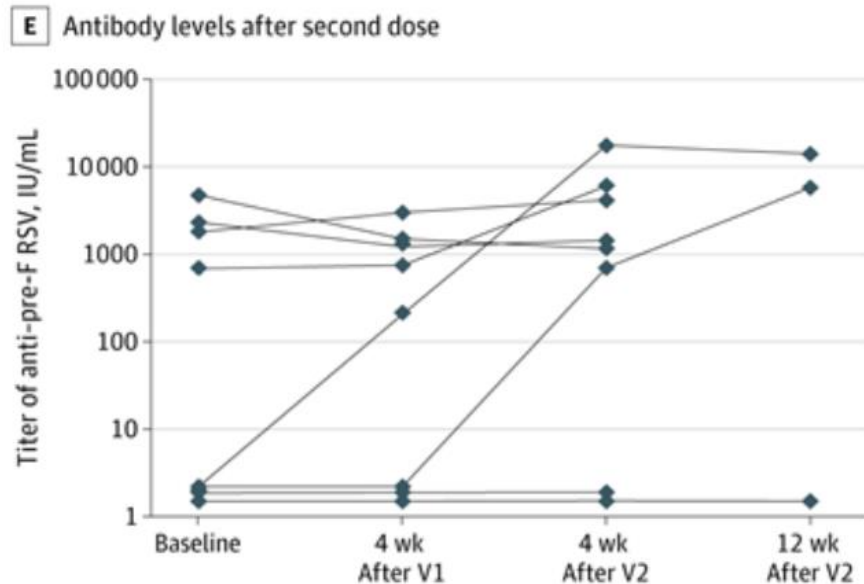
Redjoul *et al*, JAMA 2025¹

Revaccinated if:

Undetectable anti-Pre-F IgG at baseline AND titer at 4 weeks post-vaccination below 1000 UI/ml,

OR

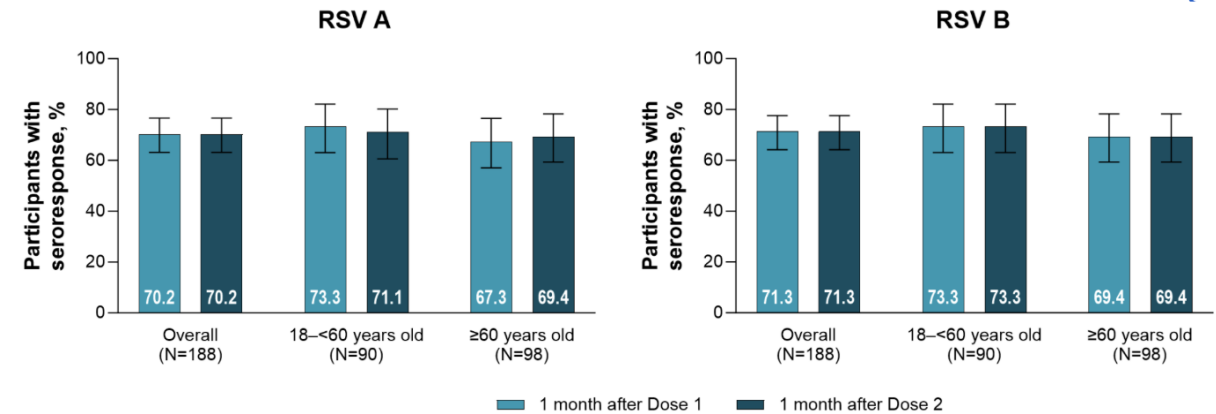
Detectable anti-Pre-F IgG below 5000 UI/ml at baseline AND titer at 4 weeks post-vaccination below 5000 UI/ml and 2-fold basal level.



Almeida *et al*, Vaccines 2025²

Bivalent RSV vaccine in immunocompromised or renally impaired adults

A small number of those who didn't achieve a seroresponse after the first dose, did after the second dose (8 and 9 out of 54 and 56 of RSV-A and RSV-B.



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ECIL 11 RSV vaccine recommendations for Allo-HCT

Vaccine Timing

- All adult allo-HCT recipients should receive a single dose of RSV vaccine prior to the RSV season, preferably ≥ 12 months post-transplant when they are not in receipt of ongoing immunosuppressive treatment **(B II u)**.
- Adult allo-HCT recipients ≥ 6 but less than 12 months post-transplant, and those ≥ 12 months with active GVHD and/or ongoing immunosuppressive treatment, and not previously vaccinated should be considered for RSV vaccination in the case of community outbreak, though responses are likely to be blunted **(C II u)**.
- A second dose of RSV vaccine in the following season can be considered for adult allo-HCT recipients who received an initial dose of RSV vaccine at 6 – 12 months post-transplant or were ≥ 12 months with active GVHD and/or ongoing immunosuppressive treatment at time of vaccination **(Not graded)**.

Vaccine type

- Any of the approved RSV vaccines as there is insufficient evidence to favour one over the other in transplant patients **(Not graded)**.

ECIL 11 RSV Vaccine Recommendations for Auto-HCT

Vaccine Timing

- Twelve months after autologous transplant, RSV vaccination should follow general population recommendations, though the age threshold may vary by country **(B II t)**.
- Adult auto-HCT recipients ≥ 12 months with ongoing immunosuppression, and those $\geq 6 - 12$ months post-transplant should be considered for RSV vaccination in the case of community outbreak **(C III)**

Vaccine type

- Any of the approved RSV vaccines as there is insufficient evidence to favour one over the other in transplant patients **(Not graded)**.

ECIL 11 RSV Vaccination Recommendations for Paediatric HCT patients

There is insufficient evidence to recommend RSV vaccination in paediatric populations at this time **(D)**.

Patient contacts

- Household contacts should be encouraged to receive age-appropriate RSV vaccination whenever possible **(Not graded)**

Regionally-limited and travel vaccines after HCT

- Chikungunya
- Dengue
- Hepatitis A virus
- Malaria
- Monkeypox
- Rabies: *WHO recommendations*
- Tickborne encephalitis
- Typhoid fever: *WHO recommendations*
- Yellow fever

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Chikungunya vaccination

ECIL 11 guidelines for HCT recipients

- Chikungunya vaccination with a virus-like particle vaccine can be considered in HCT recipients traveling to a high-risk area (Chikungunya outbreak) or in a moderate risk area if long or frequent travel despite the absence of data in HCT recipients

CIII

- The live-attenuated vaccine is not recommended due to more side effects

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ECIL11 guidelines for Dengue vaccination in HCT recipients

- Currently, dengue vaccination relies only on live-attenuated vaccines
- There are no data about dengue vaccines after HCT
- In very specific situations, vaccination might be considered after at least 2 years after transplant, in the absence of GVHD and immunosuppressive therapy. The choice of vaccine depends on availability in the given country

No grading

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ECIL 11 proposal for HAV vaccination

The HCT recipients should be vaccinated according to the recommendations for the general population in each country from 12 months after transplant, either with a HAV vaccine (2 doses), or with a conjugate HAV-HBV vaccine (3 doses)

BIU

There is no specific safety issue in this population

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ECIL 11 guidelines for Malaria vaccination after autologous /allogeneic HCT in adults and children

- **The malaria vaccines (R21/Matrix-M and RTS,S/AS01/Mosquirix) are not currently standard traveler vaccines. The vaccines are currently not recommended for immunocompromised adult patients and patients after autologous/allogeneic HCT**
- CDC recommends malaria vaccines only for children aged 5-36 months and 6 weeks-17 months respectively, living in moderate-to-high transmission areas of malaria caused by *Plasmodium falciparum*
- There are no data in immunocompromised children other than children with HIV infection. However for immunocompromised children including those after auto/allogeneic HCT age < 36 months living in endemic area, vaccination should be considered on an individual basis

DIII



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Monkeypox (Mpox) ^{3/3}; ECIL11 proposals

The vaccinia live-attenuated, replicative-deficient, vaccine (Imvanex or Jynneos) is safe in immunocompromised hosts and immunogenic in HCT recipients vaccinated from 2 years after transplant (*Walsh SR, JID 2013*)

However, the vaccine efficacy is unknown in immunocompromised patients

Vaccination with one of these vaccines can be considered from 2 years after HCT in recipients older than 12 years, according to the local recommendations:

- occupational exposure
- at-risk patients in the setting of an outbreak (as locally defined)
- known contact with an infected individual: in that case, the vaccination should be done within 4 days after the contact

Earlier post-exposure need of protection should use specific immunoglobulins

The live-attenuated replicative vaccine is contraindicated

No grading

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www.cdc.gov/monkeypox/hcp/vaccine-considerations/index.html; www.who.int/wer; Rao et al, MMWR 2022

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WHO recommendations – 2019

Curr Opin Infect Dis 2019, 32:401–406

- ✓ **Pre-exposure** (occupationally exposed, travelers to high-incidence regions):
 - 2 doses of vaccines d0, and ideally d7 (or later)
 - 3 doses in immunocompromised hosts: d0, d7, and d21-28
- ✓ **Post-exposure:**
 - 3 doses (d0, d3, d7 by ID route, or alternative regimens by IM route)
 - + Rabies Ig: if category III exposure or if category II exposure in case of immunosuppression

> The ECIL group endorses the WHO recommendations



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Tick-borne encephalitis (TBE): the disease

- Flavivirus (3 subtypes: European, Siberian, Far-Eastern); the European subtype dominates in the EU/Nordic region
- Transmitted primarily by *Ixodes* ticks (*I. ricinus*, *I. persulcatus*); rarely via unpasteurised dairy. Small rodents are the reservoir
- Most infections asymptomatic; incubation median 8 days
- Typically biphasic: nonspecific febrile phase → (after 4 days) CNS phase with meningitis, encephalitis or myelitis
- **No antiviral treatment: supportive care only. Prevention by vaccination is therefore central**
- **Case-fatality ~0.5–2% (European subtype); higher with age and immunosuppression. Long-term neurological sequelae common (20-40%)**

CDC Yellow Book 2024; ECDC 2025; Skudal et al, Eur J Clin Microb Biol Infect Dis 2024

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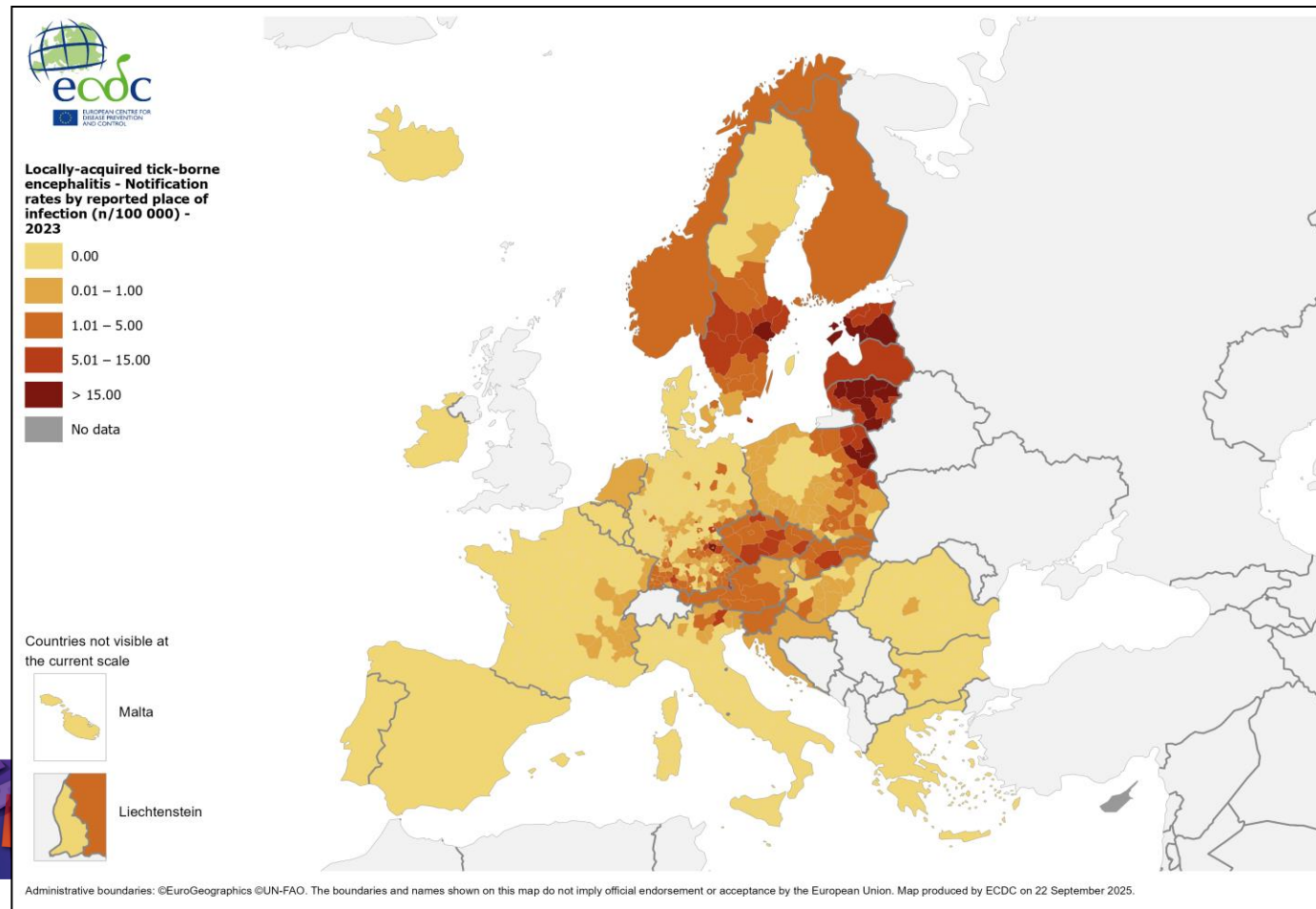
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Endemic areas are expanding

- Focally endemic across 27 European countries; ~5,000–10,000 cases/year. Risk is highly focal and shifting
- Climate change is lengthening the tick season and pushing the range northward

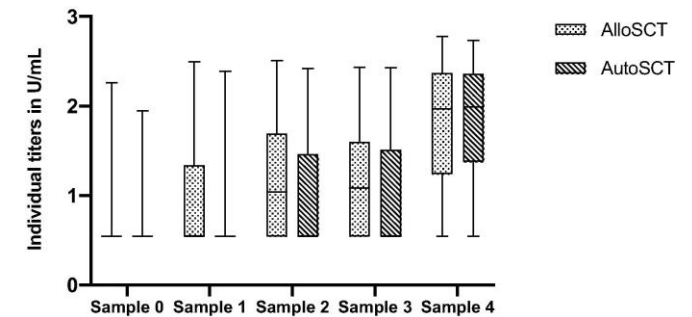


ECDC 2025

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TBE vaccine response after HCT – what we know

	Einarsdottir, Vaccine 2021	Harrison, NPJ Vaccines 2021
Country / setting	Sweden	Austria
Population	104 allo (51) and auto (53) HCT; median age 61. 27 healthy controls.	19 allo-HCT, 15 controls
Vaccine / doses	FSME-Immun (Ticovac®) 4 doses from 9 mo post-HCT	FSME-Immun (Ticovac®) 2 doses (primary endpoint) from 11-13 mo after HCT
Pre-vaccination seropositivity	13/84 (15%): 9 reported earlier TBE vaccination	15/19 (79%) protective NT titre
Main humoral result	Seropositive 77% after 4 doses (controls 100% after 3)	NT response 35% vs 93% controls after 2 doses
Predictors / take-home	GvHD: lower titres; prime with 4 doses; safe. No difference in responses auto vs allo.	CD4+ count predicts response; response attenuated and delayed
Safety	5 SAEs; none vaccine-related. No worsening of GvHD (patient with severe GvHD were not included)	4 SAEs; none vaccine-related. Local side-effects common. Two pts with worsening of GvHD; coinciding with reduction of IS.



Four doses needed post HCT
(Einarsdottir et al, Vaccine 2021)

ECIL 11 proposed recommendations for TBE vaccination

Recommendation for HCT recipients (auto- and allo-)	Grade
Indication follows national recommendations and individual exposure: patients residing in endemic areas, or travelling to them with anticipated outdoor exposure (e.g. hiking, camping, forestry) during tick season	Allu
Either licensed vaccine; only FSME-Immun has been studied post-HCT	Not graded
Initiate vaccination from 9 months post-transplant	BIlu
Extended primary series of 4 doses, then boosters per national schedule (immunocompromised)	BIlu
Counsel on tick-bite avoidance (clothing, repellents, tick checks): especially before full vaccination and throughout B-cell aplasia	Not graded

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**Typhoid vaccines: WHO
position paper – March 2018**

**Vaccins antityphoïdiques: note
de synthèse de l'OMS – mars
2018**

Typhoid fever

Mainly in Asia and sub-saharian Africa, and in low and middle income countries, mainly in children 5-15 y

No case reported after HCT

No data on Typhoid vaccination after HCT

Available vaccines (variable according to the country):

- conjugated polysidic vaccine Typbar-TCV: *better early and prolonged immunity than ViPS*
- polysidic vaccine ViPS
- oral, live-attenuated vaccine: Ty21a

WHO recommendations (2018) for immunocompromised patients:

- Immunocompromised pts should receive the TCV or ViPS vaccine.
- Ty21a is not recommended



> The ECIL group endorses the WHO recommendations

What's new between 2017-2026 on Yellow Fever and HCT?

- Several studies have confirmed the frequent post-transplant persistence of YF-Abs in allogeneic HCT recipients who have been vaccinated before transplant or whose donor has been vaccinated (*Avelino-Silva VI, Hum Vaccines Immunother 2016; Sicre de Fontbrune F, JID 2018; Adler M, JID 2018*)
⇒ Confirms the recommendation to assess the anti-YF Abs before vaccination of HCT recipients, in order to avoid an unnecessary safety risk
- A new generation LAV YF vaccine (vYF) which was shown to be comparable (neutralizing Ab titers at d29, 6 and 12 months, and safety) to YF-VAX in a randomized, observer-blinded, phase 2 trial (*Feroldi E. NEJM 2026*), but not assessed after HCT

✓ **ECIL 11 Guidelines: No change**



General recommendations

- Donor vaccination
- Specific considerations for different modalities of transplantation

Please note that the other general recommendations are mentioned at the end of Part II (Vaccine guidelines for CAR-T and bispecifics recipients)

- Assessment of individual vaccine response and durability of the response
- Immunoglobulin infusions and vaccination in HCT recipients
- Vaccination of household members
- Vaccination of the healthcare workers in the hematology ward

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Donor vaccination

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New data: Covid19 and donor vaccination

Recommendations for the management of COVID-19 in patients with haematological malignancies or haematopoietic cell transplantation, from the 2021 European Conference on Infections in Leukaemia (ECIL 9)

Simone Cesaro^{1,3}, Per Ljungman^{2,3}, Malgorzata Mikulska⁴, Hans H. Hirsch^{5,6,7}, Marie von Lilienfeld-Toal^{8,9}, Catherine Cordonnier¹⁰, Sylvain Meylan¹¹, Varun Mehra¹², Jan Styczynski¹³, Francesco Marchesi¹⁴, Caroline Besson¹⁵, Fausto Baldanti¹⁶, Raul Cordoba Masculano¹⁷, Gernot Beutel¹⁸, Herman Einsele¹⁹, Elie Azoulay²⁰, Johan Maertens²¹, Rafael de la Camara²², ECIL 9* and Livio Pagano²³

Leukemia 2022



“There is no specific recommendation for vaccinating stem cell donors for any other purpose than protecting the donor.

- However, previous vaccination of the donor might reduce the risk to jeopardise the donation”.

ECIL 11: At least two studies showed that recipients transplanted from a vaccinated donor had a better vaccine response when vaccinated at 3 months after transplant (*Leclerc M, Lancet Haematol 2022; Sherman AC, TCT 2023*). However, this question is outdated since most donors have now received a full vaccination program

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Donor vaccination

ECIL 7

HSCT donors should be vaccinated according to the recommended schedule in their country.

The possible benefit of donor vaccination before harvest on the immune response of the recipient after transplant could exist for vaccine-preventable diseases, which can become severe early after HSCT such as Flu and *S pneumoniae*.

The benefit is marginal for vaccines to which the immune response is already excellent without donor vaccination (ie. *H influenzae* B).

ECIL11: no change

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Reviewed in Harris et al. BMT 2015)

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Specific guidelines for different modalities of AUTOLOGOUS HCT?

Autologous HCT recipients are mostly included in the studies when they received maintenance therapy but few specific data on their vaccine response exist:

- small series or small proportions of pts receiving a given type of maintenance
- heterogeneous maintenance therapies
- large series but maintenance used as a stratification criteria (*Bastidas et al 2019*)

Lenalidomide does not significantly impair the vaccine response to pertussis, diphtheria, tetanus, HiB, S pn, polio, HAV and HBV, especially when vaccination starts from 12 months after transplant (*Palazzo M, BBMT 2018*)

Rituximab : no new data

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Specific guidelines for different modalities of ALLOGENEIC HCT?

Vaccine response after:

- **Haplo-id HCT:** few data, conflicting results, mostly no significant difference
(Kondolot M, TCT 2023; Cordonnier C, CID 2015)
- **CD34-selected HCT:** After CD34-selected myeloablative allogeneic HCT, the response to vaccines *seems to be lower* than after non-T cell depleted HCT, even when vaccination is started ≥ 1 y after transplant, especially for PCV (no control group) (Melica G, BMT 2024)
- **Cord blood HCT:** conflicting results (Shah GL BBMT 2015; Haynes AS, TCT 2021)
- **RIC vs. MAC:** better response reported after RIC (Garcia-Garrido H, AJH 2022)

In summary: conflicting results, mainly depending on the vaccine and the timing of vaccination

Common findings are the impact of **severe GvHD** and of **Rituximab** administration on the vaccine response, whatever the type of donor, transplant and conditioning



Thank you for your attention,
and thank you for your comments and suggestions

Please send your questions or suggestions to
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