British Society for Haematology
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Professor Andrew Pollard
Chair, The Joint Committee on Vaccination and Immunisation

Dear Professor Pollard

We are writing as the British Society of Haematology which represents professionals across UK haematology. A large number of the patients we care for are classified as 'Clinically Extremely Vulnerable' (CEV) to COVID-19 infection. The clinical risk to these individuals is likely to have been underestimated because of the effects of prior successful shielding. It is clear that individuals with haematological diseases have a very high mortality rate if they contract COVID-19 infection and a minimal chance of survival if they get severe COVID-19 related complications. (Vijenthira et al, Passamonti et al, Telfer et al). As such, we would argue that they should be placed in an even higher priority group.

We appreciate your intention to maximise the short-term impact of the vaccination programme through prioritising delivery of a first dose of vaccine to as many eligible individuals as possible over delivery of a second vaccine dose to fewer patients. However, whilst a lower degree of protection for a period may be appropriate for the overall (and generally healthy) population it is not ideal for our patients as it may put them at significant disadvantage, especially if they are not able to mount normal immune responses. Patients with blood cancers and with sickle cell disease frequently have reduced humoral and cellular immunity and often have less robust responses to other vaccines. (Yri et al, Rousseau et al, Nagant et al).

We are concerned that patients with haematological disease who are on immunosuppressive therapies or whose illness is associated with an immune defect are likely to have an impaired response to vaccination and that this may be compromised further if the dosing schedule is suboptimal.

Whilst we accept that there is a lack of clinical evidence about response to the vaccine in the immune suppressed/compromised patients, the current published evidence base for optimal vaccination protection for the Pfizer vaccine trial is on a two-dose schedule (Polak et al). We would ask the JCVI to consider that this group should be offered a second vaccine dose at three or four weeks after their initial vaccine, in line with currently available published evidence, international recommendations and authorisation by the UK regulator.

We would welcome a discussion of these issues with you at the earliest opportunity.

Yours Sincerely

Professor Adele Fielding, President
Dr Josh Wright, Vice President

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Dr John Ashcroft, Treasurer
Dr Jim Seale, Trustee
Dr Katrina Farrell, Chair of the Communications Committee
Professor Jo Howard, Chair of the Guidelines Committee

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