Differences in Homing Potentials of *Streptococcus pneumoniae*–Specific Plasmablasts in Pneumococcal Pneumonia and After Pneumococcal Polysaccharide and Pneumococcal Conjugate Vaccinations

Nina V. Palkola,¹,²,³ Sari H. Pakkanen,¹ Jussi M. Kantele,⁵ Laura Pakarinen,² Ritvaleena Puohiniemi,⁴ and Anu Kantele²,³

¹Department of Bacteriology and Immunology, ²Department of Clinical Medicine, University of Helsinki, ³Inflammation Center, Clinic of Infectious Diseases, ⁴Department of Clinical Microbiology, HUSLAB, Helsinki University Hospital and University of Helsinki, and ⁵Department of Medical Microbiology and Immunology, University of Turku, Finland

**Background.** Mucosal immune mechanisms in the upper and lower respiratory tracts may serve a critical role in preventing pneumonia due to *Streptococcus pneumoniae*. *Streptococcus pneumoniae*–specific plasmablasts presumably originating in the lower respiratory tract have recently been found in the circulation in patients with pneumonia. The localization of an immune response can be evaluated by exploring homing receptors on such plasmablasts, yet no data have thus far described homing receptors in pneumonia.

**Methods.** The expression of α₄β₇, L-selectin, and cutaneous lymphocyte antigen (CLA) on *S. pneumoniae*–specific plasmablasts was examined in patients with pneumonia (n = 16) and healthy volunteers given pneumococcal polysaccharide vaccine (PPV; n = 14) or pneumococcal conjugate vaccine (PCV; n = 11).

**Results.** In patients with pneumonia, the proportion of *S. pneumoniae*–specific plasmablasts expressing L-selectin was high, the proportion expressing α₄β₇ was moderate, and the proportion expressing CLA was low. The homing receptor α₄β₇ was expressed more frequently in the pneumonia group than in the PPV (P = .000) and PCV (P = .029) groups, L-selectin was expressed more frequently in the PPV group than in the PCV group (P = .014); and CLA was expressed more frequently in the pneumonia group than in the PPV group (P = .001).

**Conclusions.** The homing receptor profile in patients with pneumonia was unique yet it was closer to that in PCV recipients than in PPV recipients. These data suggest greater mucosal localization for immune response in natural infection, which is clinically interesting, especially considering the shortcomings of vaccines in protecting against noninvasive pneumonia.

**Keywords.** pneumonia; *Streptococcus pneumoniae*; pneumococcus; pneumococcal polysaccharide vaccine; PPV; pneumococcal conjugate vaccine; PCV; mucosal immune response; lymphocyte homing; homing receptor.

Pneumonia is a major cause of death worldwide, with *Streptococcus pneumoniae* one of the most frequent pathogens [1, 2]. Control of the disease through vaccination has become an objective for preventive health care. The disease begins by the establishment of *S. pneumoniae* colonization in the upper respiratory tract (URT), followed by descent of the bacteria into the lower respiratory tract (LRT) to bring about a symptomatic infection [1, 2]. Nasopharyngeal carriage is clearly a prerequisite for all *S. pneumoniae* diseases [2], yet the immunological factors protecting against transition from carriage to disease are not adequately understood.
Mucosal antibodies capable of preventing colonization may offer a key approach to protection [3–7]. Indeed, in animal models mucosal vaccines eliciting mucosal antibodies have proved to confer protection against local disease [5, 7, 8]. To develop better vaccination strategies, local immune mechanisms need to be explored in greater detail in humans.

Pneumococcal vaccines, either as 23-valent polysaccharide preparations (PPV) or 10- or 13-valent polysaccharide vaccines conjugated to a protein carrier (PCV10 and PCV13, respectively), are licensed in many countries. PPV covers a broader spectrum of serotypes and confers protection against invasive pneumococcal disease, while the efficacy against local, noninvasive pneumonia remains controversial [9–11]. PCVs cover fewer serotypes and are not only effective against invasive pneumococcal disease [12], but also seem to confer some protection against noninvasive pneumonia (efficacy, 20%–37%) [13–15]. The insufficient ability of vaccines to elicit mucosal immune response has been suggested to account for their shortcomings in providing protection against local disease [5].

During an immune response, effector B lymphocytes (plasmablasts) do not spread equally across the body but instead are guided to travel to sites of expected antigen encounter. This tissue-specific homing of lymphocytes from blood into tissues is based on interaction between lymphocyte surface chemokine receptors (CCR) and homing receptors with chemokines and specific homing receptor-ligands, addressins, on the endothelial cells of the target tissues, respectively [16, 17]. Tissue-specific homing receptors have been identified: L-selectin (CD62L) guides the lymphocytes to the peripheral lymph nodes [18], αβ-,β2-integrin guides lymphocytes to the intestinal lamina propria [19], and cutaneous lymphocyte antigen (CLA) guides lymphocytes to skin tissue [20]. Analysis of the homing receptor and/or CCR profiles of the circulating plasmablasts provides an approach to evaluate the targeting of an immune response elicited at the site of antigen encounter [21–24]. The homing receptors guiding lymphocytes to the LRT have not been identified, but it has been suggested that instead of a single homing receptor, a variety of homing receptors are involved [16, 17, 25].

We have recently detected S. pneumoniae–specific plasmablasts in the circulation of humans with acute pneumococcal pneumonia [26]. These cells are presumed to originate in the LRT and to be responsible for distributing the immune response to various immunological compartments of the body [26]. Exploring these S. pneumoniae–specific plasmablasts allows study of the localization of the immune effector cells of the LRT. Comparing the homing receptor profiles of S. pneumoniae–specific plasmablasts between patients with pneumonia and volunteers who receive parenteral S. pneumoniae vaccines may throw new light on possible differences between natural infection and PPV or PCV in targeting the immune response.

METHODS

Patients, Healthy Volunteers, Vaccines, and Samples

The study protocol was approved by the Ethics Committee of the Department of Medicine at the Helsinki University Hospital. Written informed consent was obtained from all subjects. The study was registered at ClinicalTrials.gov with the identifier NCT01402245.

The 16 patients (8 women and 8 men aged 30–67 years) with acute pneumonia caused by S. pneumoniae composed the same group presented in our recent study [26] who had pathogen-specific antibody-secreting cells (ASCs) in peripheral blood specimens one week after the onset of symptoms. The diagnostic criteria are presented in that report.

A total of 14 healthy, previously unimmunized volunteers (9 women and 5 men aged 25–48 years) were enrolled in the PPV group, and 11 healthy, previously unimmunized volunteers (7 women and 4 men aged 24–40 years) were enrolled in the PCV group. The PPV group was vaccinated with Pneumovax (Sanofi Pasteur MSD, Brussels, Belgium), a 23-valent commercial PPV in which each dose contains 0.025 mg of capsular polysaccharide of serotypes 1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 12F, 14, 15B, 17F, 18C, 19A, 19F, 20, 22F, 23F, and 33F. The PCV group was given Prevenar (Pfizer Inc. [previously Wyeth Lederle Vaccines]), a 7-valent PCV containing 0.002 mg of capsular polysaccharide of serotypes 4, 9V, 14, 18C, 19F, and 23F conjugated with CRM157 protein and 0.004 mg of serotype 6B conjugated with CRM157 protein. Each vaccinee received 0.5 mL of Pneumovax or Prevenar into the left deltoid muscle on day 0.

A blood sample was collected from patients with pneumonia 7–10 days after symptom onset and from vaccinees on days 0 and 7 after vaccination. This timing was based on our previous studies of mucosal [23, 27, 28] and parenteral [22] vaccination: following antigen encounter, ASCs appear in the circulation on days 2–3, peak on day 7, and are no longer found on day 14. Peripheral blood mononuclear cells (PBMCs) isolated using Ficoll-Paque and fractionated into receptor-positive and receptor-negative populations were analyzed with an enzyme-linked immunospot (ELISPOT) assay to determine the numbers of S. pneumoniae–specific ASCs and all immunoglobulin-secreting cells (ISCs). The ELISPOT assay identified separately the cells of immunoglobulin A (IgA), immunoglobulin G (IgG), and immunoglobulin M (IgM) isotypes.

Antigen

In the pneumonia group, S. pneumoniae isolates from cultures of blood specimens obtained from each patient were grown on chocolate agar plates, killed with formalin, and used as antigen in the ELISPOT assay, as described previously [29, 30]. In the ELISPOT assay for vaccinated volunteers, purified pneumococcal capsule polysaccharide 14 (ATCC; Bethesda, Maryland) was used as antigen. To observe possible differences between whole...
bacteria and capsular polysaccharide as antigens, 1 representative patient with pneumonia was analyzed by the ELISPOT assay, using the S. pneumoniae strain recovered from the patient, and by another ELISPOT assay performed with a mixture of purified capsular polysaccharides (23F, 3, 4, 5, 6B, 7F, 8, 14, and 19F [ATCC]; 10 µg/mL of each type).

Separation of Receptor-Negative and Receptor-Positive Cell Populations
Separation of PBMCs into homing receptor–positive and homing receptor–negative populations has been described earlier [22, 29, 31]. Briefly, aliquots of cell suspensions were incubated on ice with antihuman α4β6 (ACT-1), antihuman L-selectin (Leu 8), or antihuman CLA (HECA-452) and washed. Next, the cells were incubated on ice with Dynal M-450 magnetic beads coated with sheep antimouse IgG, followed by magnetic separation. The receptor-positive and receptor-negative cell populations were immediately studied by the ELISPOT assay.

ELISPOT Assay of Specific ASCs and All ISCs
The ELISPOT assay for pathogen-specific ASCs has been described previously [29]. In brief, 96-well microtiter plate wells were coated with a whole-cell preparation of the S. pneumoniae strain from each patient or, for vaccinees, with pneumococcal capsule polysaccharide 14. The cells were incubated in the wells for 2–3 hours, and antibodies secreted during this time were detected with alkaline phosphatase–conjugated antihuman IgA, IgG, and IgM. The substrate was added in melted agarose. Enumerated under a light microscope, each spot was interpreted as a print of 1 ASC.

The receptor-positive and receptor-negative cell populations were assayed for all ISCs, using the ELISPOT as previously described [32].

Statistical Analysis
The numbers of S. pneumoniae–specific ASCs for individual subjects were obtained by totaling their receptor-positive and receptor-negative ASCs in the 3 receptor assays and calculating the mean of these values. The total ASC numbers in each group were presented as median values with ranges. The data were log transformed and proved to be normally distributed; the differences between the study groups were assessed by analysis of variance. The proportion of ASCs expressing a given receptor was given as the arithmetic mean ± standard deviation (SD). To obtain reliable statistics, we included in the homing receptor analyses only subsets that fulfilled the statistical criteria: the homing receptor data were normally distributed in all groups. Differences were considered statistically significant when the P value was <.05.

RESULTS
Pneumococcal Isolates in Patients with Pneumonia
The patients’ S. pneumoniae isolates were serotyped at the reference laboratory of the Institute of Health and Welfare. Each strain was determined to be serotype 4, 6B, 7F, 9V, 14, or 23F.

General Characteristics of ASC Responses
The magnitude of the S. pneumoniae–specific response (IgA- +IgG+IgM-ASCs) was similar in the 3 study groups. In the pneumonia group, the median total number of pathogen-specific ASCs (IgA+IgG+IgM) was 152/106 PBMCs (range, 22–2039 ASCs/106 PBMCs; Figure 1A), and the median total number was 12 ASCs/106 PBMCs (range, 0–1235 ASCs/106 PBMCs) for IgA-ASCs, 119 ASCs/106 PBMCs (7–749 ASCs/106 PBMCs) for IgG-ASCs, and 5 ASCs/106 PBMCs (0–176 ASCs/106 PBMCs) for IgM-ASCs.

No S. pneumoniae–specific ASCs were found in the healthy volunteers before vaccination (Figure 1B and 1C). On day 7, S. pneumoniae–specific ASCs were detected in all subjects in both vaccination groups. The median count was 491 ASCs (IgA+IgG-+IgM)/106 PBMCs (range, 92–8327 ASCs/106 PBMCs) in the PPV group (Figure 1B) and 265 ASCs/106 PBMCs (range, 43–812 ASCs/106 PBMCs) in the PCV group (Figure 1C).

As for the isotype distribution, data on the pneumonia group have been reported previously [26]. In the PPV group, the median values for S. pneumoniae–specific IgA-ASCs, IgG-ASCs, and IgM-ASCs were 199 ASCs/106 PBMCs (range, 20–2955 ASCs/106 PBMCs), 182 ASCs/106 PBMCs (range, 9–3575 ASCs/106 PBMCs), and 15 ASCs/106 PBMCs (range, 0–1798 ASCs/106 PBMCs), respectively (Figure 2A), and the predominating isotype was IgA in 6 of 14 volunteers and IgG in 8 of 14 volunteers (Figure 2A). In the PCV group, the respective median values were 82 ASCs/106 PBMCs (range, 1–212 ASCs/106 PBMCs), 109 ASCs/106 PBMCs (range, 19–626 ASCs/106 PBMCs), and 10 ASCs/106 PBMCs (range, 0–153 ASCs/106 PBMCs; Figure 2B), and the response was dominated by IgA-ASCs in 3 of 11 volunteers, by IgG-ASCs in 7 of 11, and by IgM-ASCs in 1 of 11 volunteers (Figure 2B).

Expression of α4β7, L-selectin, and CLA on S. pneumoniae–Specific ASCs
The homing receptor expressions in the 3 study groups are shown in Figure 3. The mean proportion (±SD) of α4β7–expressing...
The majority of \( \text{S. pneumoniae} \)-specific ASCs expressed L-selectin in all the groups: the arithmetic mean proportions (±SD) of L-selectin–expressing cells were 79% ± 16%, 89% ± 9%, and 73% ± 20% for the pneumonia, PPV, and PCV groups, respectively.

\[ \text{Figure 1. Streptococcus pneumoniae--specific plasmablast response in the pneumonia, pneumococcal polysaccharide vaccine (PPV), and pneumococcal conjugate vaccine (PCV) groups. A, Numbers of plasmablasts (antibody-secreting cells [ASCs])/10^6 peripheral blood mononuclear cells (PBMCs) specific to the S. pneumoniae isolate from each of the 16 patients in the acute phase of the disease (7–10 days after onset of symptoms). B and C, Numbers of S. pneumoniae (serotype 14 capsule polysaccharide)–specific ASCs/10^6 PBMCs on days 0 and 7 for 14 volunteers immunized with PPV (B) and for 11 volunteers immunized with PCV (C). The spots connected with a line indicate the ASC counts for individual subjects; the bars represent the medians.} \]

\[ \text{Figure 2. Isotype distribution of the Streptococcus pneumoniae--specific plasmablast response in the pneumococcal polysaccharide vaccine (PPV) and pneumococcal conjugate vaccine (PCV) groups. The numbers of S. pneumoniae--specific immunoglobulin A (IgA)--antibody-secreting cells (ASCs), immunoglobulin G (IgG)--ASCs, and immunoglobulin M (IgM)--ASCs per 10^6 peripheral blood mononuclear cells (PBMCs) on day 7 are presented for each individual, connected with a line. Data are shown separately for the PPV (n = 14; A) and PCV (n = 11; B) groups. The bars indicate the median value of each isotype. The respective data for the patients with pneumonia have been presented in our previous report [26].} \]
respectively. The expression was more frequent in the PPV group, compared with the PCV group ($P = .014$) but did not differ between the pneumonia and the vaccination groups.

The mean proportion (±SD) of CLA-expressing cells among $S. \text{pneumoniae}$–specific ASCs was higher in the pneumonia group (14% ± 17%), compared with the PPV group (2% ± 3%; $P = .001$), while no difference was found between the pneumonia and the PCV groups (5% ± 7%; Figure 3).

The isotype distribution of the patients’ $S. \text{pneumoniae}$–specific ASCs with a given homing receptor is provided in Figure 4.

Despite the nonidentical antigens used in the ELISPOT assay for patients with pneumonia (ie, the strain recovered from each patient) and vaccinees (purified $S. \text{pneumoniae}$ polysaccharide), there was no indication of methodological reasons for the differences in homing receptor expressions. In a representative patient, the homing receptor expressions proved similar regardless of whether the patient’s own $S. \text{pneumoniae}$ strain or a mixture of $S. \text{pneumoniae}$ polysaccharide antigens had been used in coating (26% and 25% for $\alpha_4 \beta_7$, 85% and 87% for L-selectin, and 8% for CLA).

Expression of L-selectin, $\alpha_4 \beta_7$, and CLA on All ISCs in the Pneumonia Group

The homing receptor profile of the $S. \text{pneumoniae}$–specific ISCs from patients with pneumonia is presented separately for each isotype in Figure 4.

**DISCUSSION**

Pneumococcal colonization is considered a prerequisite for $S. \text{pneumoniae}$ pneumonia [1, 2]. However, carriage in itself is known to induce mucosal antibodies that may prevent colonization [3, 6–8, 33] and protect against pneumonia [34]. It has been suggested that aspirating or inhaling colonizing organisms during the first few weeks of colonization may lead to pneumonia, whereas after this period the individuals may be protected against the disease because of mucosal antibodies [34]. Consistent with the role of protective immune mechanisms induced by previous exposure, recurrences of pneumonia are rarely seen in immunocompetent individuals [35]. To design vaccines that elicit protective immune mechanisms closely mimicking those during an infection, in-depth information on natural immune responses is needed. The present study is the first to focus on the localization of LRT-originating B cells in a natural infection in humans. We explored the homing receptor expressions of newly activated plasmablasts in the circulation of patients with pneumonia. Significant differences in the homing profiles were revealed between patients with pneumonia and volunteers who received PPV or PCV.

The exact activation site in the human LRT is not known. Likewise, the homing receptors guiding lymphocytes to the LRT have not been fully identified, but a variety of them are
Lung lymph have been shown to be B cells originating in the LRT. Effector/memory T cells in sheep with T cells, our study explores homing receptor expression on $\alpha_4\beta_7$-expressing, L-selectin–expressing, and cutaneous lymphocyte antigen (CLA)–expressing plasmablasts among circulating *Streptococcus pneumoniae*–specific plasmablasts (ASCs) and the total of ISCs, given separately for IgA (dotted bars), IgG (white bars), and IgM (hatched bars) isotypes and their total (black bars). The numbers of cases included in the pooled data are indicated under the bars.

Figure 4. Expression of homing receptors on immunoglobulin A (IgA)–antibody-secreting cells (ASCs), immunoglobulin G (IgG)–ASCs, immunoglobulin M (IgM)–ASCs, and all immunoglobulin-secreting cells (ISCs) in patients with pneumonia. The bars show the arithmetic mean values ($\pm$SD) of percentages of $\alpha_4\beta_7$–expressing plasmablasts among circulating *S. pneumoniae*–specific plasmablasts (ASCs) and the total of ISCs, given separately for IgA (dotted bars), IgG (white bars), and IgM (hatched bars) isotypes and their total (black bars). The numbers of cases included in the pooled data are indicated under the bars.

assumed to contribute to this migration [16, 17, 25, 36, 37]. While most studies on lung homing have been carried out with T cells, our study explores homing receptor expression on B cells originating in the LRT. Effector/memory T cells in sheep lung lymph have been shown to be $\alpha_4\beta_7^{\text{low}}$ and L-selectin$^{\text{low}}$ [38]. Likewise, human lung T cells are $\alpha_4\beta_7^{\text{low}}$ [39, 40], L-selectin$^{\text{low}}$ to $\text{low}$ [39], and CLA$^{\text{low}}$ to $\text{low}$ [40] or CLA$^{\text{high}}$ to $\text{low}$ [39], a profile different from that of cells migrating to the gut ($\alpha_4\beta_7^{\text{high}}$, L-selectin$^{\text{low}}$, and CLA$^{\text{low}}$) and skin ($\alpha_4\beta_7^{\text{low}}$, L-selectin$^{\text{high}}$, and CLA$^{\text{high}}$) [39, 40].

The possible role of $\alpha_4\beta_7$, L-selectin, and CLA in plasmablast homing to the LRT remains unclear. In the light of T-cell studies, our results showing a moderate proportion of $\alpha_4\beta_7$–expressing B cells (44%) and a high frequency of L-selectin–expressing B cells (79%) were both somewhat unexpected. Bronchus-associated lymphoid tissue (BALT) found in patients with lung carcinoma appears to recruit both naive and memory/effector lymphocytes, with $\alpha_4$-integrin and L-selectin expressed on nearly all B cells and less than half of T cells [36]. In the same study, BALT proved positive for the endothelial ligands PNAAd (peripheral lymph node addressin) and VCAM-1 (vascular cell adhesion molecule-1), but not MAdCAM-1 (mucosal vascular addressin cell adhesion molecule-1). The great proportion of $\alpha_4$–expressing B cells in BALT may imply the presence of either $\alpha_4\beta_1$–integrins or $\alpha_4\beta_7$–integrins, both of which can bind VCAM-1 [19, 41], a ligand much more common in human BALT than in peripheral lymph nodes and Peyer patches [25, 36]. Recently, $\alpha_4\beta_7$ has been shown to contribute substantially to lymphocyte recruitment to the human LRT in inflammation [35]. While T-cell homing to the LRT may not be mediated by $\alpha_4\beta_7$ [37, 39, 40], in mice, $\alpha_4\beta_7$/VCAM-1 interaction participates in the homing of mast cells [41]; the role of $\alpha_4\beta_7$ in B-cell homing to the LRT remains unclear.

While pneumonia is preceded by pneumococcal colonization of the URT, plasmablasts in the present study might, in fact, also have originated in the URT. However, in our ongoing study of patients with sinusitis, such a strong plasmablast response is only seen in an acute disease, not in prolonged cases. Furthermore, the homing receptor profile in acute URT infection differs from that presented here for patients with pneumonia (N. V. Palkola, unpublished data). Thus, we understood the homing receptors in the present study to reflect the destinations of LRT–originating circulating plasmablasts trafficking both to lung tissue and other potential mucosal sites: our data suggest that both L-selectin and $\alpha_4\beta_7$ contribute to distributing the humoral immune response elicited in the human LRT.

The first of the 2 fundamental findings of the present study was that, in pneumonia (in which antigen is encountered in the LRT), the homing profile differed from those reported previously in any of the other sites—after parenteral tetanus toxoid vaccination [42], oral [22, 23], rectal [23], and parenteral [22] typhoid vaccination, or intranasal [21] and rectal [21] cholera vaccination, as well as in mucosal infections in the intestine [29, 43] or urinary tract [42]. These studies have shown that cells activated in the intestine [21–23] all express $\alpha_4\beta_7$, while only a moderate proportion express L-selectin, and practically none express CLA and that intranasal immunization [21] elicits a response with a great proportion of $\alpha_4\beta_7$-expressing and L-selectin–expressing cells. Parenteral vaccination [22, 42], by contrast,
elicits a response in which the proportion of $\alpha_4\beta_7$-expressing cells is low, the proportion of L-selectin–expressing cells is high, and the proportion of CLA-expressing cells is moderate. The present study is the first to explore the homing receptor profile of plasmablasts originating in the LRT. It shows that plasmablasts in patients with pneumonia are characterized by a high proportion of L-selectin–expressing, moderate $\alpha_4\beta_7$–expressing, and low CLA-expressing cells. The unique homing receptor profile in pneumonia appears to agree with the general understanding that the localization of an immune response depends on the site of antigen encounter [23]. It also accords with mucosal route of antigen encounter being more potent than parenteral route in inducing mucosal response [3, 6, 7]. Interestingly, significant coexpression of various homing receptors was found, a phenomenon also seen after booster immunization in our previous research [44]. Consistent with the unique homing receptor profile of B cells in our study, the expression of known homing signals of human lung T cells has been found distinct from gut-homing and skin-homing T cells [39, 40].

The high expression of L-selectin detected in pneumonia agrees with reports of PNAd expression in the LRT [25, 36]. The role of $\alpha_4\beta_7$, on the other hand, deserves discussion. One of its 2 potential ligands, VCAM-1, is expressed in the lung tissue, while the main ligand, MAdCAM-1, is not [25, 41, 36]. The $\alpha_4\beta_7$ expression may reflect a number of points: (1) a role for $\alpha_4\beta_7$ in lymphocyte homing to the LRT, as discussed above; (2) a booster-type response to a previous encounter with *S. pneumoniae* in the URT or the intestine [44, 45]; or, most logically, (3) communication between mucosa-associated tissues in the body, with immunization at one mucosal site leading to an immune response at others [23], presumably serving to ensure protection at potential sites of future antigen encounter. Indeed, the main ligand for $\alpha_4\beta_7$, MAdCAM-1, has been shown to be expressed not only in the intestine but also in the URT [46]—the optimal location for an immune response serving to ward off bacterial pneumonia.

The second of our 2 major findings was that the homing receptor profile of plasmablasts in *S. pneumoniae* pneumonia differed from that after receipt of PPV and PCV. As for PPV, this was seen in 2 of the homing receptor types examined: in the patients with pneumonia the proportion of cells expressing $\alpha_4\beta_7$ and CLA was greater than in the PPV group. The homing receptor profile in the PCV group was found to be closer to that in patients with pneumonia, with merely 1 difference: $\alpha_4\beta_7$ was expressed more frequently in the pneumonia than the PCV group.

The high frequency of L-selectin–expressing plasmablasts in all study groups accords both with the role of L-selectin as a homing receptor guiding cells to the systemic immune system [18] and indications of its participation in B-cell homing to the lung [25, 36]. The more frequent expression of $\alpha_4\beta_7$ among patients with pneumonia than vaccinees, on the other hand, suggests a more mucosa-oriented homing from the LRT, discussed above. Intriguingly, poor immune response localization to mucosal sites, especially to the URT and/or LRT, as suggested by the low frequency of $\alpha_4\beta_7$-expressing cells after parenteral *S. pneumoniae* vaccination, might explain the shortcomings of *S. pneumoniae* vaccines in protecting against local disease. While both PPV and PCV appear to contribute to the local pulmonary immune response through serum-derived antibodies [47], PCV, unlike PPV, has also been shown to be able to reduce colonization by *S. pneumoniae* [48]. Furthermore, as yet another indication of local immunity, PCVs have proven to be efficacious against acute otitis media [49]. PCVs thus appear to contribute to mucosal immunity more than PPVs; consistently, the homing receptor profile in the PCV group was closer to that in the pneumonia group.

The limitations of this research include 2 points to be discussed: the selection of patients and the homing receptors chosen for examination. Only bacteremic patients with pneumonia could be recruited, because in them the individual *S. pneumoniae* isolate could be retrieved from blood culture and used as antigen. In these cases, however, even if the first pathogen encounter occurs in the respiratory tract, bacteria may trigger some additional systemic stimulation. While this may skew the homing receptor profile in the pneumonia group toward a systemic rather than local type, it is remarkable that, compared with vaccinees, the homing receptor profile in pneumonia showed a trend toward a more mucosa-oriented type, even though only bacteremic patients had been included. While the present data do not allow comparisons between homing receptor profiles of bacteremic and nonbacteremic patients with pneumonia, in our previous study the homing receptor profile of subjects with urosepsis and nonbacteremic pyelonephritis was similar, and the bacteremia per se was not found to have any effect on the homing receptor expressions [42].

Because of the restricted number of PBMCs available, only 3 homing receptors could be explored. It would, however, have been interesting to examine other markers, as well. One of the reasons for selecting $\alpha_4\beta_7$, L-selectin, and CLA was that these have been studied in infections at other mucosal sites [29, 42, 43], enabling comparisons. Even if all potential markers guiding cells home to the LRT were not covered, the differences detected through these 3 suggest a unique homing receptor profile for plasmablasts activated in the human LRT.

In conclusion, 2 important novel aspects are revealed in this study: (1) circulating pathogen-specific plasmablasts in patients with pneumonia have a unique homing profile quite unlike that found at other mucosal sites, and (2) the homing receptor profile in patients with pneumonia is more mucosa oriented than that seen after administration of PPV or PCV yet closer to that in PCV recipients than in PPV recipients. Dissimilarities in the localization of immune response may contribute to the differing efficacy of these vaccines against noninvasive versus invasive *S. pneumoniae* diseases.
Notes

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