and Dimmock, 1985; Renegar et al., 1998]. The polymeric nature of S-IgA also explains why S-IgA cross-reacts with variant influenza viruses to a greater extent than serum IgG [Tamura et al., 1990, 1991, 1992; Asahi-Ozaki et al., 2004]. Thus, intranasal administration of an inactivated influenza vaccine is advocated to elicit S-IgA and IgG responses and improve the protective efficacy of current vaccination procedures [Tamura and Kurata, 2004; Tamura et al., 2005, 2010].

Several clinical trials have examined the induction of both S-IgA and IgG following intranasal administration of inactivated influenza vaccines, either with or without adjuvant [Kuno-Sakai et al., 1994; Hashigucci et al., 1996; Muszkat et al., 2000; Greenbaum et al., 2002; Durrer et al., 2003; Treanor et al., 2006; Atmar et al., 2007]. The antibody responses after intranasal administration of inactivated influenza vaccines were assessed by measuring hemagglutination inhibition (HI) titres in the serum, and anti-hemagglutinin (HA) IgA and IgG titres in nasal wash samples. They did not measure the titre of neutralizing antibodies, which is considered to be a better criterion for functional protective antibodies. Neutralization titres can directly inhibit the complex process involved in virus replication, which include virus attachment and entry to the host cells, and release of newly-synthesized virus from the infected cells in tissue culture. In addition, a previous study found that HI titres were lower, or higher, than the corresponding neutralization titres, depending on a strain of influenza A or B virus used for the assay [Okuno et al., 1990], whereas other studies show that anti-H5 HI antibodies fail to detect H5N1 viruses [Lu et al., 1982; Rowe et al., 1999]. Thus, neutralizing antibody responses following intranasal administration of an inactivated influenza vaccine remain to be fully characterized.

Therefore, the aim of the present study was to examine the levels and properties of neutralizing-antibodies in nasal wash and serum samples from healthy adults after intranasal administration of an inactivated vaccine (five doses, with an interval of 3 weeks between each dose). The inactivated vaccine used in this study was a concentrated split-virus vaccine (containing 45 μg HA per dose), prepared from the A/Uruguay/716/2007 (H3N2) strain. A concentrated split-virus vaccine was chosen because the vaccine has already been shown to induce mucosal antibody responses after intranasal vaccination [Kuno-Sakai et al., 1994]. To ensure that neutralization titres specific for the A/Uruguay/716/2007 virus were assayed at equivalent levels in both serum and nasal wash samples, the neutralization titres were measured using concentrated nasal wash samples (1 mg/ml total protein) that contained approximately 1/10 of the IgA found in undiluted mucus [Kurono and Mogi, 1987]. The properties of the neutralizing IgA and IgG antibodies induced by intranasal vaccination were then examined, and their relative levels and molecular size were determined.

## MATERIALS AND METHODS

### Subjects

Five healthy male subjects (P1, P2, P3, P4, and P5) were enrolled in the study (aged 22, 32, 42, 42, and 68 years, respectively, at the time of the first vaccination). All participants had already acquired some degree of immunity to H1N1 and H3N2 influenza A virus subtypes after previous exposure to these viruses and/or as a result of previous vaccinations. Each subject provided informed consent and the study protocol and other relevant documentation were reviewed and approved by the Ethics Committee of the National Institute of Infectious Diseases (Tokyo, Japan).

### Virus and Vaccine

The A/Uruguay/716/2007 (A/Uruguay; H3N2) influenza virus strain was propagated in the allantoic cavity of 10-day-old embryonated hen's eggs and purified from the allantoic fluid. The $TCID_{50}$ (50% infectious dose in tissue culture) of the virus was estimated as described previously [Tobita et al., 1975; Kadowaki et al., 2000]. In brief, 10-fold serial dilutions of the allantoic fluid containing the virus were inoculated into Madin-Darby canine kidney (MDCK) cells (ATCC No. CCL-34) cells in 96-well culture plates and incubated for 4 days at 37°C in a 5% $CO_2$ humidified atmosphere. The cytopathic effects in the virus-containing wells were monitored under a microscope and the $TCID_{50}$ was calculated using the Reed–Muench method. The split product virus vaccine was supplied by the Research Foundation for Microbial Disease of Osaka University (BIKEN, Kanonji, Japan). The vaccine was prepared from purified viruses, which were sedimented through a linear sucrose gradient according to the manufacturer's protocol. The viruses were then treated with ether and formalin according to the manufacturer's protocol, which was based on the method of Davenport et al. [1964]. The concentrated split vaccine containing 45 μg HA was the product of a process used to prepare a trivalent vaccine comprising A/H1N1, A/H3N2, and B type vaccines, each containing 15 μg HA.

### Vaccinations

All participants were immunized intranasally with a threefold concentrated split H3N2 virus vaccine (A/Uruguay, containing 45 μg HA). Each received five doses, with an interval of 3 weeks between each dose. Intranasal vaccination was performed by spraying 0.25 ml of the split vaccine into each nostril (0.5 ml total) using an atomizer (Keytron, Ichikawa, Japan). The mean droplet diameter was 56.5 μm, ranging in size between 10 μm and 90 μm.

### Nasal Wash and Serum Samples

About 100 ml of nasal wash was collected from each participant in polypropylene tubes by washing the

nasal cavity several times using a nose irrigation device (Hananoa; Kobayashi Pharmaceutical, Osaka, Japan) filled with saline solution according to the manufacturer's instructions. Pieces of dental cotton (Dental Cotton Roll; B.S.A. Sakurai, Nagoya, Japan) were then immersed in the collected nasal washes. Dental cotton pieces (containing a combined absorbed volume of about 25 ml of nasal wash) were then placed into a filter insert (Oxi Fil filter insert; TOHO, Tokyo, Japan) with bottoms drilled to create several pores, and placed in 50 ml polypropylene centrifuge tubes. Clean nasal wash was separated from mucopolysaccharides and other debris by centrifugation at 2,200*g* for 5 min at room temperature. This procedure was repeated for the entire 100 ml nasal wash sample from each participant. The pooled, clean nasal wash was then concentrated to a final volume of approximately 0.5 ml using Vivaspin centrifugal concentrators (Vivaspin 20, MWCO = 30,000; Sartorius Stedim Biotech, Aubagne, France). The concentrated nasal wash was stored at −80°C before use.

### Quantitation of IgA, IgG and IgM Antibodies and Other Proteins

The levels of human IgA, IgG, and IgM antibodies in the nasal wash and serum samples were estimated using human IgA, IgG, or IgM ELISA kits (Bethyl Laboratories, Montgomery, USA). The level of human serum albumin in the nasal wash samples was estimated using a Human Albumin ELISA kit (Bethyl Laboratories). The protein concentration in the samples was measured using either a BCA Protein Assay Kit, or a Micro BCA Protein Assay Kit (Thermo Fisher Scientific, Yokohama, Japan) according to the manufacturer's instructions.

### Neutralization Assays

The level of serum antibodies against the vaccine viruses was examined using micro-neutralization assays as previously described [Belshe et al., 2000; Kadowaki et al., 2000] with minor modifications. In brief, serum samples were treated with a receptor-destroying enzyme (RDE(II); Denka Seiken, Tokyo, Japan) overnight at 37°C and heat-inactivated for 30 min at 56°C before use. The first dilution tested in the assays was 1:10. The concentrated nasal wash samples [1 mg/ml total protein, corresponding to about 1/10 of the total IgA found in nasal mucus (2.20 mg/ml)] [Kurono and Mogi, 1987] were also treated with RDE(II) and heat-inactivated before use. The first dilution tested in the nasal wash assays was 1:20. Twofold serial dilutions of the serum samples were mixed with an equal volume (50 μl) of diluent containing influenza virus equivalent to 100 $TCID_{50}$. Each mixture was added to the wells of a 96-well plate containing a monolayer of MDCK cells. Four control wells were included on each plate and contained either virus or diluent alone. The plates were then incubated for 4 days at 37°C in a 5% $CO_2$-humidified atmosphere. The monolayer in each well was observed for the presence or absence of cytopathic effects, fixed with 10% formalin for more than 5 min at room temperature, and stained with Naphthol blue black. After the plates were washed and dried, the stained cells were solubilized with 0.1 M NaOH and the absorbance (A) was measured at 630 nm. The average $A_{630\ nm}$ value was determined from quadruplicate virus-infected wells ($A_{virus}$) and cell culture-only controls ($A_{cell}$). All values above 50% of the specific signal, calculated using the formula: $X = (1/2) \times (A_{cell} - A_{virus}) + A_{virus}$, were considered positive for neutralization. The titres recorded were the reciprocal of the highest dilution, where $A_{630}$ was $>X$.

### Hemagglutination Inhibition

The antibody responses to the vaccine viruses were examined in serum and nasal washes using HI antibody assays incorporating a microtiter method as described elsewhere [Hierholzer et al., 1969]. All samples were pre-treated with RDE(II) at 37°C for 18 hr, subsequently inactivated at 56°C for 30 min, and mixed with packed red blood cells to remove any nonspecific inhibitors. The starting material for the assays was a 1:10 dilution for the serum samples and a 1:40 dilution for the nasal wash samples.

### Fractionation of Nasal and Serum Samples

The concentrated nasal wash samples (100 μl, 6 mg/ml) and diluted serum samples (10-fold dilution, 100 μl, about 6 mg/ml) were fractionated on a Superose 6 10/300 GL gel filtration column using an FPLC-AKTA chromatography system (GE Healthcare, Little Chalfont, UK). The concentrated nasal wash sample was treated with 1 μg/ml of lysozyme (Sigma-Aldrich, St. Louis, MO) for 1 hr at 37°C to decrease the viscosity and then centrifuged using Vivaspin to remove the lysozyme prior to gel filtration. Fractions (each 500 μl) were collected in PBS at a flow rate of 0.1 ml/min; little or no change in the fractionation pattern of the antibodies in the concentrated nasal wash samples was observed following lysozyme treatment. Molecular weight marker proteins (Kit for Molecular Weights 29,000–700,000 Da; Sigma-Aldrich) were eluted under the same conditions to determine the size of each fraction.

## RESULTS

### Measurement of Neutralization and HI Titres in Concentrated Nasal Wash Samples

The total protein level and the levels of IgA, IgG, and IgM and human serum albumin in 100 ml of unconcentrated nasal wash and in approximately 0.5 ml of concentrated nasal wash are shown in Table I. About 70% of the total nasal wash proteins were lost during the concentration process. Also, a fraction of the higher molecular weight (MW) proteins and lower MW proteins (less than 30 kDa) was lost by

TABLE I. Concentration of IgA, IgG, IgM and HSA in 0.5 ml of Solution Concentrated From 100 ml of Nasal Wash (n = 10)*

| Unit | Concentration: Mean ± SD | | | | |
|---|---|---|---|---|---|
| | Total protein | IgA | IgG | IgM | HSA |
| Nasal wash (n = 10) | | | | | |
| Unconcentrated | | | | | |
| mg/100 ml | 5.875 ± 1.856 | 1.132 ± 0.678 | 0.125 ± 0.057 | 0.032 ± 0.021 | 0.531 ± 0.280 |
| Concentrated | | | | | |
| mg/0.43 ± 0.06 ml | 1.647 ± 0.549 | 0.375 ± 0.193 | 0.093 ± 0.044 | 0.007 ± 0.006 | 0.292 ± 0.214 |
| Concentration calculated in terms of total protein (mg/ml) | 1.00 | 0.217 | 0.057 | 0.004 | 0.177 |

*The concentration was calculated using two nasal wash samples collected from five participants (with a 1 week interval).

adsorption to the cotton and during Vivaspin centrifugation, respectively. However, better recovery was observed for IgA and IgG. When the concentration of the enriched nasal washes was adjusted to 1 mg/ml total protein, the amount of IgA was 0.217 mg/ml. This amount of IgA in the concentrated nasal wash corresponded to about 1/10 of the levels of total IgA recovered from nasal mucus (2.20 mg/ml) by aspiration as reported by Kurono and Mogi [1987] (Table I). In subsequent experiments, neutralization and HI titres in the nasal wash samples were measured using concentrated nasal wash proteins (1 mg/ml of total protein), which contained 1/10 of the IgA found in mucus, to ensure that the nasal and serum neutralization titres were assayed at equivalent levels.

The amount of total IgA and total IgG in the nasal wash samples from each participant varied slightly at each sampling time. Also, the level of total IgA and IgG antibodies did not increase significantly between pre-vaccination and post-vaccination in any of the participants. Thus, the average amount of total IgA or total IgG in the nasal wash samples from the five participants was relatively constant (data not shown).

## Neutralizing Antibody Responses in Nasal Wash and Serum Samples

Next, antibody responses in the nasal wash and serum samples were examined in all five study participants. The responses are presented as neutralization titres against the A/Uruguay (H3N2) virus in Table II. The responses recorded in the four young adults (between 18- and 50-years-old) are also shown as geometric neutralization titres (Fig. 1). The nasal wash and serum neutralization titres increased in all participants as the number of vaccinations increased, although the degree of increase differed between participants. In addition, nasal wash neutralization titres increased more rapidly than serum titres. The nasal wash titres showed at least a fourfold increase after the second vaccination in the four young participants (all of whom had a nasal wash neutralization titre of 1:20 or 1:40 before vaccination). By contrast, a fourfold increase in the serum titre was observed only after the fifth vaccination in three of the participants (all of whom had serum titres of <1:10, 1:20, or 1:40 before vaccination). Participant P5, who was 67 years old, showed at least a fourfold increase in nasal wash titre after the fourth vaccination, but no significant

TABLE II. Neutralizing Antibody Responses in Subjects who Received the Threefold Concentrated A/Uruguay/716/2007 (H3N2) Split Vaccine

| Weeks (vaccination) | Neutralization titre against A/Uruguay virus (H3N2)[a] | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | P1 | | P2 | | P3 | | P4 | | P5 | |
| | Nasal wash | Serum | Nasal wash | Serum | Nasal wash | Serum | Nasal wash | Serum | Nasal wash | Serum |
| 0 (1st) | 20 (1) | 40 (2) | 20 (1) | <10 (<0) | 40 (2) | 20 (1) | 20 (1) | <10 (<0) | 20 (1) | <10 (<0) |
| 3 (2nd) | 80 (3) | 160 (4) | 20 (1) | <10 (<0) | 80 (3) | 20 (1) | 20 (1) | <10 (<0) | 40 (2) | <10 (<0) |
| 6 (3rd) | 160 (4) | 160 (4) | 80 (3) | 10 (0) | 320 (5) | 20 (1) | 80 (3) | <10 (<0) | 40 (2) | <10 (<0) |
| 9 (4th) | 320 (5) | 160 (4) | 160 (4) | 20 (1) | 1280 (7) | 40 (2) | 160 (4) | 10 (0) | 40 (2) | <10 (<0) |
| 12 (5th) | 320 (5) | 160 (4) | 320 (5) | 40 (2) | 2560 (8) | 80 (3) | 80 (3) | 10 (0) | 80 (3) | <10 (<0) |
| 15 | 1280 (7) | 160 (4) | 320 (5) | 40 (2) | 2560 (8) | 80 (3) | 160 (4) | 20 (1) | 160 (4) | 10 (0) |
| 28 | 640 (6) | 160 (4) | 160 (4) | 40 (2) | 1280 (7) | 80 (3) | N.D. | N.D. | 80 (3) | 10 (0) |

N.D., not done.
[a]Respective values are a reciprocal titre and a geometric titre ($10 \times 2^n$) in a parenthesis.

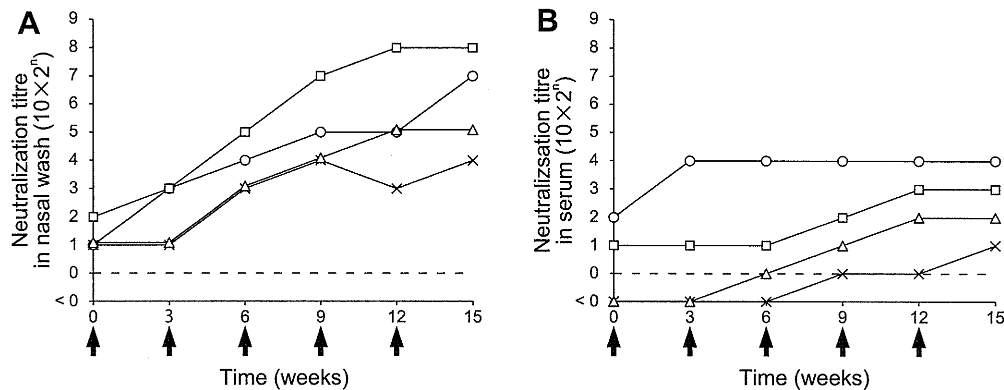


Fig. 1. Nasal wash and serum sample neutralization titres against A/Uruguay (H3N2) (pre- and post-intranasal immunization). Neutralization titres against the A/Uruguay virus in nasal washes (**A**) and serum (**B**) were determined in samples collected from four participants (18–60 years old; P1, open circle; P2, open triangle; P3, open square; and P4, cross). The participants were given five doses of the threefold concentrated A/Uruguay split influenza vaccine intranasally with an interval of 3 weeks between doses (each arrow indicates a point of vaccination). The neutralization titre shown is the geometric titre.

increase was observed in serum titre after five vaccinations. In all participants, the nasal wash and serum titres were largely maintained, even at 16 weeks after the fifth vaccination, at which point the nasal wash titre decreased only slightly, while no decrease was observed in the serum titre (Table II).

## HI Antibody Responses in Nasal Wash and Serum Samples

Antibody responses were also examined by measuring the HI titre against the A/Uruguay (H3N2) virus. Table III shows the pre-vaccination HI titres of the nasal wash and serum samples from two participants, and the HI titres 3 weeks after each of the five vaccinations. For each participant, the HI titres were lower than the neutralization titres shown in Table II. The HI titres were approximately 1/4–1/8 the level of the neutralization titres. Statistical correlation analysis

TABLE III. Hemagglutinin Inhibition (HI) Antibody Responses in Subjects who Received the Threefold Concentrated A/Uruguay/716/2007 (H3N2) Split Vaccine

| | HI titre against A/Uruguay virus (H3N2)[a] | | | |
|---|---|---|---|---|
| | P1 | | P2 | |
| Weeks (vaccination) | Nasal wash | Serum | Nasal wash | Serum |
| 0 (1st) | N.D. | 10 (0) | <40 (<2) | <10 (<0) |
| 3 (2nd) | <40 (<2) | 20 (1) | <40 (<2) | <10 (<0) |
| 6 (3rd) | <40 (<2) | 20 (1) | <40 (<2) | <10 (<0) |
| 9 (4th) | 40 (2) | 20 (1) | <40 (<2) | 10 (0) |
| 12 (5th) | 40 (2) | 20 (1) | 80 (3) | 20 (1) |
| 15 | 160 (4) | 40 (2) | 80 (3) | 20 (1) |

N.D., not done.
[a]Respective values are a reciprocal titre and a geometric titre ($10 \times 2^n$) in a parenthesis.

of the data presented in Tables II and III showed a strong correlation between the HI titres and the neutralization titres (r = 0.8699). Thus, the HI titre correlated with the neutralization titre, although it was less sensitive than the neutralization titre.

## Fractionation of The Nasal Wash and Serum Samples

The types of antibody present in the nasal wash and serum samples were examined after fractionation on a gel filtration column. The concentrated nasal wash samples (100 μl, about 6 mg/ml) and diluted serum samples (10-fold diluted sera, 100 μl, about 6 mg/ml) were fractionated on a Superose 6 column in PBS. The antibody concentration in each fraction was then measured by ELISA. Figure 2 shows the profiles for IgM, IgA, and IgG antibodies, together with the absorbance values for the total protein in each fraction. The nasal wash samples contained IgM, which comprised less than 1% of the total protein and showed a peak MW of 970 kD; IgA, which comprised about 20% of the total protein and showed a peak MW of about 660 kD; and IgG, which comprised about 6% of the total protein and showed a peak MW of 150 kD. The MW of the nasal IgA (150 kD–900 kD, with a peak MW of 660 kD) appeared to correspond to that of tetrameric IgA (the MW of dimeric IgA is estimated to be about 360 kD). The maximum absorbance value observed in the protein profile (at around 66 kD) was due to the presence of human serum albumin (Fig. 2A).

The serum samples contained IgM, which comprised about 3% of the total protein and showed a peak MW of 970 kD; IgA, which comprised about 6% of the total protein and showed a peak MW of about 150 kD; and IgG, which comprised about 23% of the total protein and showed a peak MW of 150 kD

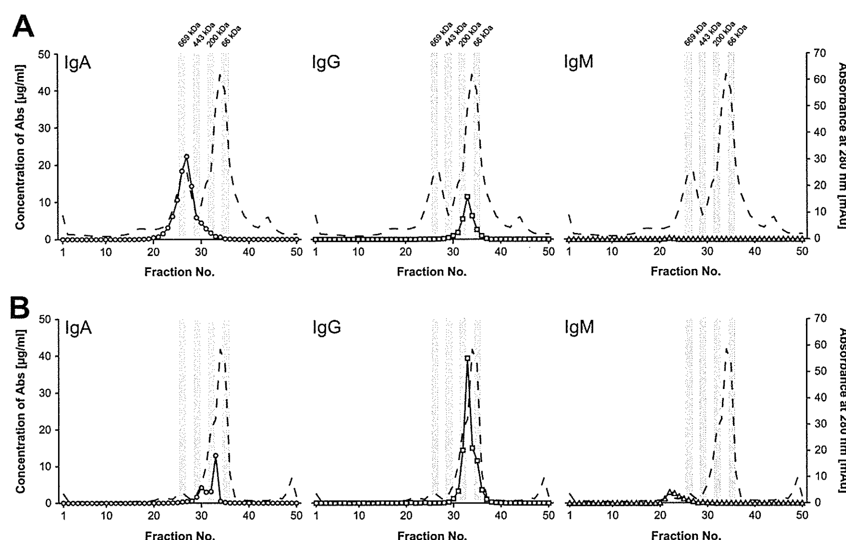


Fig. 2. Fractionation of nasal wash (**A**) and serum (**B**) samples from representative participants on Superose 6 columns. Quantification (μg/ml) of IgA (open circles), IgG (open squares), or IgM (open triangles) antibody levels and the absorbance at 280 nm (mAu, broken line) are shown. The grey zones in the upper part of the curves indicate the positions of the molecular weight markers [thyroglobulin (669 kD), apoferritin (443 kD), β-amylase (200 kD), and bovine serum albumin (66 kD)].

(Fig. 2B). Serum IgA (which showed a lower peak at about 360 kD in addition to a peak at about 150 kD) appeared to comprise both monomeric and dimeric IgA.

Taken together, the results of the fractionation analysis suggests that highly polymeric IgA is the predominant nasal antibody, and can be separated from nasal IgG and IgM. By contrast, the monomeric forms of IgG are the major component of total serum antibodies.

### Neutralization Activity of the IgA and IgG Antibodies in The Nasal Wash and Serum Samples

To determine the isotype of the antibodies responsible for the neutralization activity induced by intranasal administration of the inactivated vaccine, nasal wash and serum samples from participant P1, who showed relatively high neutralization titres after the fifth vaccination, were separated on a Superose 6 column and the neutralization titre of the resulting antibody fractions assayed. The nasal polymeric IgA fraction (No. 27) showed a neutralization titre of 1:10, whereas the nasal monomeric IgG fraction (No. 33) showed a reciprocal neutralization titre of <1:10. However, the serum dimeric IgA fraction (No. 30) showed a neutralization titre of <1:10, whereas the serum peak monomeric IgG fraction (No. 33) showed a neutralization titre of 1:10 (Table IV). The respective peak fractions in the nasal wash were then concentrated to 100 μg/ml, and the neutralization activity of the nasal IgA antibodies (a mixture of fractions 26 and 27) was compared with that of the nasal IgG antibodies (a mixture of fractions 33 and 34). The nasal IgA fractions showed a neutralization titre of 1:40, whereas the nasal monomeric IgG fractions showed a neutralization titre of 1:10. Similarly, the neutralization activity of the serum IgA antibodies (100 μg/ml; a mixture of fractions 30 and 31) was compared with that of serum IgG antibodies (a mixture of fractions 33 and 34). The serum IgA fractions showed a neutralization titre of <1:10, whereas the serum

TABLE IV. Neutralization Titre of the IgA and IgG Fractions From the Nasal Wash and Serum Samples Following Separation on Superose Columns

| | Neutralization titre[a] | | | |
|---|---|---|---|---|
| | Nasal wash | | Serum | |
| | Polymeric IgA | IgG | Dimeric IgA | IgG |
| A/Uruguay (A/H3N2) | | | | |
| Peak fraction: Separated on Superose column | 10 (0) | <10 (<0) | <10 (<0) | 10 (0) |
| Concentrated fraction (100 μg/ml) | 40 (2) | 10 (0) | <10 (<0) | 10 (0) |

The samples were collected from a representative subject vaccinated five times with an interval of 3 weeks between vaccinations.
[a]Respective values are a reciprocal titre and a geometric titre ($10 \times 2^n$) in a parenthesis.

IgG fractions showed a neutralization titre of 1:10 (Table IV).

The peak polymeric IgA fraction (about 600 kD) from the nasal wash samples, as measured using an IgA ELISA, contained no IgG antibodies when measured using an IgG ELISA; however, the peak monomeric IgG fractions (about 150 kD) from the nasal wash comprised about 1/4 of IgA (data not shown). By contrast, about 1/10 of the peak dimeric IgA (about 380 kD) from the serum samples comprised IgG antibodies, whereas about 1/10 of the peak monomeric IgG fractions from the serum comprised IgA (data not shown). This suggests that nasal polymeric IgA is responsible for the neutralization activity observed in the peak polymeric IgA fractions (about 600 kD) from the nasal wash samples. Serum monomeric IgG appears to be responsible for the neutralization activity observed in the peak monomeric IgG fractions (about 150 kD) from the serum, because the IgA content of the IgG fractions was very small. In those nasal monomeric IgG fractions that contained a relatively high amount of IgA, both IgG and IgA may be responsible for the neutralization activity. Taken together, these results show that the main neutralizing antibody in the nasal mucus is highly polymeric IgA, while the main neutralizing antibody in the serum is monomeric IgG.

## DISCUSSION

In the present study, neutralizing antibody responses and their properties were examined in nasal and serum samples from healthy adults after intranasal administration of a concentrated, inactivated split A/Uruguay (H3N2) vaccine (containing 45 μg HA per dose). The first intranasal administration of a concentrated split vaccine in young adults was conducted by Kuno-Sakai et al. [1994] and showed that both serum HI- and nasal HA-specific IgA antibodies were induced after two aerosol vaccinations, which protected against a challenge infection with a cold-adapted live virus vaccine. In the present trial, neutralizing antibody responses were examined in both serum and nasal wash samples obtained from adults given five doses of vaccine, with an interval of 3 weeks between doses. The nasal wash samples were concentrated to ensure that nasal and serum neutralization titres were assayed at equivalent levels (Table I).

To measure the concentration of IgA and IgG antibodies in the concentrated nasal wash samples, the standardized nasal wash samples were adjusted to 1 mg/ml of total protein, and contained about 1/10 amount of IgA and IgG found in natural nasal mucus [Kurono and Mogi, 1987]. Previous studies show that the total amounts of IgA and IgG increase between pre-vaccination and post-vaccination in BALB/c mice [Tamura et al., 1990, 2010]; however, the results of the present study show that the amount of total IgA (and other antibodies) recovered from the nasal mucus showed small variations at each sampling time, although this was not related to vaccination status (data not shown). Even allowing for small variations in the recovery of total IgA and IgG from the nasal mucus of each subject, the neutralization titres in the standardized nasal wash samples after vaccination appeared to be a reasonable reflection of the absolute antibody titre in the nasal mucus.

A ≥4-fold increase in the nasal neutralization titre was observed after the second vaccination in the four younger subjects, whereas a rise in the serum neutralization titre was observed only after the fifth vaccination in the three younger subjects (Table II and Fig. 1). Intranasal administration of a vaccine tends to induce inferior serum antibody responses, but superior nasal IgA responses, compared with intramuscular injection [Atmar et al., 2007]. The present study also showed that neutralization titres correlated well with HI titres, although the HI titres were lower than the corresponding neutralization titres (Table III). This result confirms the work of Okuno et al. [1990], who showed that HI titres are sometimes lower than the corresponding neutralization titres, depending on the strain of influenza A or B virus used in the HI assay.

Healthy adults who had already acquired immunity to influenza viruses due to previous natural infections or vaccinations (seropositive adults) showed both nasal and serum antibody responses induced by the nasal vaccine (Tables II and III, and Fig. 1). Clinical trials show that intranasal administration of inactivated vaccines induces both mucosal and systemic antibody responses in seropositive adults [Kuno-Sakai et al., 1994; Hashigucci et al., 1996; Muszkat et al., 2000; Greenbaum et al., 2002; Durrer et al., 2003; Treanor et al., 2006; Atmar et al., 2007]. The induction of antibody responses in seropositive people by the nasal vaccine can be explained by the notion that the seropositive people have immunological memory for influenza viruses. Previous reports show that administration of an intranasal split vaccine plus adjuvant induces both local and systemic antibody responses in naive mice, and that the adjuvant is not required for a booster dose to induce an enhanced anamnestic immune response 4 weeks later [Tamura et al., 1989, 1992]. Administration of an adjuvant together with the vaccine stimulates innate immunity via several classes of pattern-recognition receptors (such as Toll-like receptors), which leads to the acquisition of specific immune responses, including immunological memory [Tamura et al., 1991, 2005; Tamura and Kurata, 2004].

Analysis of nasal wash and serum samples after passage through Superose 6 columns showed that the major component of nasal mucus antibodies was highly polymeric IgA, while that of serum antibodies was IgG (Fig. 2). In those subjects that received five doses of the intranasal A/Uruguay (H3N2) vaccine, the highly polymeric nasal IgA fractions were responsible for the majority of the neutralizing activity, whereas

the serum IgG fractions were responsible for the majority of the neutralizing activity in the serum (Table IV). These data are in agreement with those obtained in a previous mouse model experiment, in which IgA antibodies with neutralizing activity purified from the respiratory tract of mice immunized intranasally with HA molecules from the A/Puerto Rico/8/34 (H1N1) virus were polymeric, whereas the purified IgG antibodies with neutralizing activity were monomeric [Tamura et al., 1990]. Further study of the detailed structure of IgA, which has higher MW than expected for dimeric IgA [Song et al., 1995] remains to be performed.

Previous studies show that IgA in the respiratory tract is more cross-reactive with variant influenza viruses than IgG [Tamura et al., 1990, 1991]. This cross-reactivity seems to depend on the polymeric nature of IgA [Taylor and Dimmock, 1985; Palladino et al., 1995]. Taken together, these data suggest the potential for intranasally administered inactivated vaccines to induce cross-protection against antigenic variants of viruses in pre-immunized adults.

Both serum and mucosal HA-specific ELISA antibody responses after nasal vaccination need to be examined and compared with the corresponding neutralization and HI titres. In addition, neutralizing antibody responses to other influenza vaccines (from different strains, different subtypes or types of viruses, and from different forms of vaccines such as subvirion and whole virus vaccines) after nasal vaccination remain to be examined to compare the efficacy of nasal vaccines with that of the parenteral vaccine. Some of these studies are ongoing.

In conclusion, intranasal administration of an A/Uruguay split vaccine containing 45 μg HA resulted in induced nasal and serum neutralizing antibody responses in four out of five healthy adult subjects, with a neutralization titre of >1:40 after the second and the fifth administrations, respectively. These neutralizing antibody responses were largely due to the induction of nasal polymeric IgA and serum monomeric IgG.

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