

## State of the art in marketed adjuvants and formulations in allergen immunotherapy: a position paper of the European Academy of Allergy and Clinical Immunology (EAACI)

Erika Jensen Jarolim, Martin F. Bachmann, Sergio Bonini, Lars Jacobsen, Marek Jutel, Ludger Klimek, Vera Mahler, Ralph Mösges, Philippe Moingeon, Robyn E. O'Hehir, Oscar Palomares, Oliver Pfaar, Harald Renz, Claudio Rhyner, Franziska Roth Walter, Michael Rudenko, Johannes Savolainen, Carsten B. Schmidt Weber, Claudia Traidl-Hoffmann, Thomas Kündig

### Angaben zur Veröffentlichung / Publication details:

Jensen Jarolim, Erika, Martin F. Bachmann, Sergio Bonini, Lars Jacobsen, Marek Jutel, Ludger Klimek, Vera Mahler, et al. 2020. "State of the art in marketed adjuvants and formulations in allergen immunotherapy: a position paper of the European Academy of Allergy and Clinical Immunology (EAACI)." *Allergy* 75 (4): 746–60.  
<https://doi.org/10.1111/all.14134>.

### Nutzungsbedingungen / Terms of use:

licgercopyright

Dieses Dokument wird unter folgenden Bedingungen zur Verfügung gestellt: / This document is made available under these conditions:

















#### Deutsches Urheberrecht

Weitere Informationen finden Sie unter: / For more information see:

<https://www.uni-augsburg.de/de/organisation/bibliothek/publizieren-zitieren-archivieren/publiz/>



# State-of-the-art in marketed adjuvants and formulations in Allergen Immunotherapy: A position paper of the European Academy of Allergy and Clinical Immunology (EAACI)

Erika Jensen-Jarolim<sup>1,2</sup>  | Martin F. Bachmann<sup>3</sup>  | Sergio Bonini<sup>4</sup> | Lars Jacobsen<sup>5</sup> | Marek Jutel<sup>6,7</sup>  | Ludger Klimek<sup>8</sup> | Vera Mahler<sup>9</sup>  | Ralph Mösges<sup>10,11</sup>  | Philippe Moingeon<sup>12</sup> | Robyn E. O’Hehir<sup>13</sup>  | Oscar Palomares<sup>14</sup>  | Oliver Pfaar<sup>15</sup>  | Harald Renz<sup>16</sup>  | Claudio Rhyner<sup>17</sup>  | Franziska Roth-Walter<sup>2</sup>  | Michael Rudenko<sup>18</sup>  | Johannes Savolainen<sup>19</sup>  | Carsten B. Schmidt-Weber<sup>20</sup>  | Claudia Traidl-Hoffmann<sup>21</sup>  | Thomas Kündig<sup>22</sup> 

<sup>1</sup>Institute of Pathophysiology & Allergy Research, Center of Pathophysiology, Infectiology and Immunology, Medical University of Vienna, Vienna, Austria

<sup>2</sup>The Interuniversity Messerli Research Institute, University of Veterinary Medicine Vienna, Medical University of Vienna, University of Vienna, Vienna, Austria

<sup>3</sup>Institute of Immunology, Inselspital, University of Berne, Bern, Switzerland

<sup>4</sup>Institute of Translational Pharmacology, Italian National Research Council, Rome, Italy

<sup>5</sup>ALC, Allergy Learning & Consulting, Copenhagen, Denmark

<sup>6</sup>Department of Clinical Immunology, Wrocław Medical University, Wrocław, Poland

<sup>7</sup>ALL-MED Medical Research Institute, Wrocław, Poland

<sup>8</sup>Center of Rhinology and Allergology, Wiesbaden, Germany

<sup>9</sup>Division of Allergology, Paul-Ehrlich-Institut, Federal Institute for Vaccines and Biomedicines, Langen, Germany

<sup>10</sup>CRI-Clinical Research International Ltd, Hamburg, Germany

<sup>11</sup>Institute of Medical Statistics and Bioinformatics, University of Cologne, Cologne, Germany

<sup>12</sup>Center for Therapeutic Innovation – Immuno-Inflammatory Disease, Servier, Suresnes, France

<sup>13</sup>Department of Respiratory Medicine, Allergy and Clinical Immunology (Research), Central Clinical School, Monash University and Alfred Hospital, Melbourne, Vic., Australia

<sup>14</sup>Department of Biochemistry and Molecular Biology, Chemistry School, Complutense University of Madrid, Madrid, Spain

<sup>15</sup>Department of Otorhinolaryngology, Head and Neck Surgery, Section of Rhinology and Allergy, University Hospital Marburg, Philipps-Universität Marburg, Marburg, Germany

<sup>16</sup>Institute of Laboratory Medicine, Universities of Giessen and Marburg Lung Center (UGMLC), German Center for Lung Research (DZL), Philipps Universität Marburg, Marburg, Germany

<sup>17</sup>SIAP – Swiss Institute of Allergy and Asthma Research, Davos, Switzerland

<sup>18</sup>London Allergy & Immunology Centre, London, UK

<sup>19</sup>Department of Pulmonary Diseases and Clinical Allergology, University of Turku and Turku University Hospital, Turku, Finland

<sup>20</sup>Center of Allergy and Environment (ZAUM), German Center of Lung Research (DZL) and Helmholtz I&I Initiative, Technical University, and Helmholtz Center Munich, Munich, Germany

<sup>21</sup>Institute of Environmental Medicine (IEM), Technical University Munich and Helmholtz Center Munich, Munich, Germany

<sup>22</sup>Department of Dermatology, University Hospital Zurich, Zurich, Switzerland

**Abbreviations:** Al(OH)<sub>3</sub>, aluminium hydroxide; APC, antigen-presenting cell; CaP, Calcium phosphate; CCL-1, CC-Chemokine ligand-1; CpG-ODN, cytosine-guanine dinucleotide-oligodeoxynucleotides; DCs, dendritic cells; HDM, house dust mite; LPS, lipopolysaccharide; MCT, microcrystalline tyrosine; MPL, monophosphoryl lipid A; SCIT, subcutaneous allergen immunotherapy; SLIT, sublingual allergen immunotherapy.

**Correspondence**

Prof. Erika Jensen-Jarolim, Institute of Pathophysiology and Allergy Research, Center of Pathophysiology, Infectiology and Immunology, Medical University Vienna, Spitalgasse 23, Vienna 1090, Austria. Email: erika.jensen-jarolim@meduniwien.ac.at

**Funding information**

Deutsches Zentrum für Lungenforschung, Grant/Award Number: 82DZL00502; Austrian Science Fund, Grant/Award Number: F4606-B28; Deutsche Forschungsgemeinschaft, Grant/Award Number: SFB 1021

**Abstract**

Since the introduction of allergen immunotherapy (AIT) over 100 years ago, focus has been on standardization of allergen extracts, with reliable molecular composition of allergens receiving the highest attention. While adjuvants play a major role in European AIT, they have been less well studied. In this Position Paper, we summarize current unmet needs of adjuvants in AIT citing current evidence. Four adjuvants are used in products marketed in Europe: aluminium hydroxide (Al(OH)<sub>3</sub>) is the most frequently used adjuvant, with microcrystalline tyrosine (MCT), monophosphoryl lipid A (MPLA) and calcium phosphate (CaP) used less frequently. Recent studies on humans, and using mouse models, have characterized in part the mechanisms of action of adjuvants on pre-existing immune responses. AIT differs from prophylactic vaccines that provoke immunity to infectious agents, as in allergy the patient is pre-sensitized to the antigen. The intended mode of action of adjuvants is to simultaneously enhance the immunogenicity of the allergen, while precipitating the allergen at the injection site to reduce the risk of anaphylaxis. Contrasting immune effects are seen with different adjuvants. Aluminium hydroxide initially boosts Th2 responses, while the other adjuvants utilized in AIT redirect the Th2 immune response towards Th1 immunity. After varying lengths of time, each of the adjuvants supports tolerance. Further studies of the mechanisms of action of adjuvants may advise shorter treatment periods than the current three-to-five-year regimens, enhancing patient adherence. Improved lead compounds from the adjuvant pipeline are under development and are explored for their capacity to fill this unmet need.

**KEYWORDS**

adjuvants, allergen immunotherapy, aluminium, microcrystalline tyrosine, monophosphoryl lipid A (MPLA)

**1 | INTRODUCTION**

Allergen immunotherapy (AIT) is a long-standing and effective intervention to induce tolerance in a hypersensitive patient,<sup>1</sup> and it is currently the only disease-modifying, potentially curative treatment option for allergy. Typically, AIT comprises incremental doses to achieve high cumulative doses of allergen extracts, mostly via the subcutaneous (SCIT) and often via the sublingual/mucosal route (SLIT), to induce a state of sustained tolerance.<sup>2,3</sup> Regarding the apparent heterogeneity in the field of AIT and its current coming-of-age transformations, it seemed appropriate and timely to provide a state-of-the-art position paper on adjuvants in AIT. This EAACI-task force thus aimed at providing a current and transparent overview on presently used adjuvants and formulations in AIT, and especially highlights unmet needs.

Mechanistically, AIT counteracts the predominant Th2 immunity in allergy by several well-described immunological mechanisms, altogether resulting in tolerance towards the natural exposure of the allergen. The immunological changes associated with successful AIT include the generation of allergen-specific

regulatory T and B cells,<sup>5-8</sup> both a source of the immunomodulatory cytokine IL-10,<sup>9</sup> and/or CD4 cell subsets including Th1 cells,<sup>10</sup> generation of regulatory DCs,<sup>11</sup> inhibition of Th2 responses and reduction of infiltrating inflammatory cells.<sup>5</sup> It may be not necessarily associated with decreases of allergen-specific IgE levels, and the induction of allergen-specific IgA and IgG. The most classical hallmark of AIT is the increase of allergen-specific IgG4, the only non-inflammatory IgG subclass. Allergen-specific IgG, particularly IgG4 may (a) act as a blocking antibody, trapping the allergen before it can crosslink surface-bound IgE on allergy effector cells including mast cells and basophils, for instance as neutralizing antibody in nasal fluids<sup>12</sup>; (b) interact with inhibitory IgG receptor FcRIIb and downregulate IgE-mediated signalling<sup>13,14</sup>; (c) repolarize macrophages from their allergenic phenotype M2a into tolerogenic M2b, characterized by IL-10 and CCL1 secretion.<sup>15</sup> Disappointingly, none of the described cellular or humoral biomarkers has so far been able to predict the clinical outcome of AIT,<sup>16</sup> neither in SCIT nor SLIT.<sup>17</sup> Current publications explicitly aiming to fill this gap recently added several candidates to the list of potential biomarkers, including nasal IgG4,<sup>12</sup> early IL-10

producing B cells,<sup>18</sup> IL-35,<sup>19,20</sup> follicular regulatory T cells<sup>21</sup> or human lipocalin-2, a biomarker for the clinical response in grass pollen and house dust mite SLIT.<sup>22</sup>

Overall, it is unequivocal that the AIT products applied in daily practice have clinical efficacy but there are still some drawbacks related to undesired side effects, low efficacy, long treatment duration and patient compliance.<sup>4,23,24</sup>

2 | DEFINITION OF “ADJUVANT” IN AIT

Placebo-controlled studies conducted both in Europe and the United States (US) have supported both the efficacy and safety of a variety of AIT modalities. However, over the decades, the products as well as routine clinical practices of allergists who

administer AIT have considerably diverged between the United States and Europe.<sup>25</sup> To this end, nearly all products approved for SCIT in the United States are aqueous extracts. Compared with the aqueous products in the United States, adjuvant-absorbed suspensions are preferentially used in Europe which could delay systemic absorption and reduce risk of severe anaphylactic reactions. Furthermore, it has been previously hypothesized that European AIT vaccines “may gain more acceptance because of increasing regulatory approval and lower numbers of injections”.<sup>26</sup> However, head-to-head studies of aqueous versus nonaqueous formulations which could address the relative safety profiles of these products are lacking.

In Europe, the allergoid approach has been widely undertaken under the assumption to minimize the risk of side effects. Allergoids are chemically modified allergens to reduce the IgE binding, but they

TABLE 1 The contents and specification of AIT products

Components	Characteristics	Chemical modification
Allergen extracts	Remain aqueous, native; used in SLIT and in United States for SCIT	<ul style="list-style-type: none"><li>• None</li></ul>
Allergoids	Chemically modified allergens with reduced IgE binding, and enhanced immunogenicity, used for SCIT in Europe	<ul style="list-style-type: none"><li>• Formaldehyde</li><li>• Glutaraldehyde</li><li>• Calcium cyanate</li></ul>
Adjuvants <sup>a</sup>	Achieve physical allergen depot for enhanced safety and immunogenicity, used for SCIT in Europe	<ul style="list-style-type: none"><li>• Aluminium hydroxide</li><li>• Calcium phosphate</li><li>• Microcrystalline Tyrosine (MCT)</li><li>• Monophosphoryl Lipid A (MPLA)</li></ul>

<sup>a</sup>Labelling obligatory in EU.

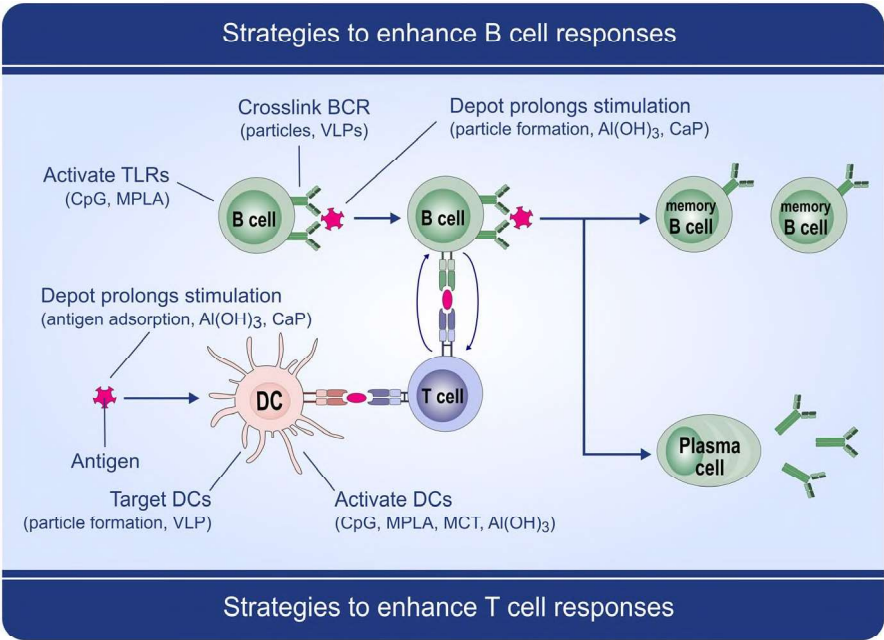


FIGURE 1 Adjuvants enhance B- and T-cell responses to the antigen by various mechanisms. Adjuvanted antigens exploit activation of Toll-like receptors (TLRs) on B cells, crosslinking of B-cell receptors (BCR) by particles such as VLPs, and depot formulation to prolong antigen stimulation. Further, adjuvanted antigen depots prolong stimulation of DCs, targeting and enhancing uptake by dendritic cells (DCs), finally leading to activation of T cells, which then help B cells to become plasma cells. MPLA, monophosphoryl lipid A; CaP, calcium phosphate; MCT, microcrystalline tyrosine

are usually not applied without adjuvants. In the adjuvants approach, allergens are physically precipitated, creating a depot at the injection site, while simultaneously enhancing immunogenicity (Table 1; Figure 1). The safety of allergoids<sup>27</sup> allows fast up dosing<sup>28</sup> and induction of IL-10 and protective antibodies,<sup>29</sup> but this strategy can be corroborated by the choice of adjuvants.<sup>30</sup> In this paper, we thus focus on the adjuvants approach, rather than on the allergoid concept. Table 1 also illustrates that the choice of methods presently used for formulation of marketed AIT products is quite limited. Adjuvants also may enhance the efficacy of AIT by polarizing the immune response towards a protective immune response. Adjuvants typically comprise danger signals, leading to inflammation and enhancing the subsequent immune response against the applied allergen. In principle, AIT adjuvants use the TLR-based vacuolar pathway or the aluminium-based cytosolic pathway and lead to enhanced cross-presentation by DCs.<sup>31</sup> Mouse studies indicate that different adjuvants may induce distinct inflammatory signatures: aluminium hydroxide (Al(OH)<sub>3</sub>) and microcrystalline tyrosine (MCT) via NALP3 inflammasome activation<sup>32</sup> induce caspase-dependent IL-1 $\beta$  secretion in a TLR-independent manner<sup>33</sup>; aluminium hydroxide induces a release of IL-5 as an initiator of eosinophilic inflammation; monophosphoryl lipid (MPL) A acting via TLR4 induced high levels of TNF- $\alpha$ , IL-1 $\alpha$  and IL-6.<sup>34</sup> These divergent immune mechanisms are especially expressed in the onset of AIT and whether these initial effects are per se beneficial or detrimental, or affect the outcomes or efficacy of AIT is not known and should be fully investigated. Therefore, each adjuvant acts via distinct immunological mechanisms, modulating adaptive as well as innate immune responses, all ultimately counteracting the Th2 response, or dampening the allergic inflammation. In marketed European SCIT products, mostly Al(OH)<sub>3</sub>, much less frequently MCT, MPL or other adjuvants are applied, as listed in Table 2 and shown in Figure 2A for grass pollen SCIT as an example.

Besides SCIT (respiratory and venom allergies) and SLIT (respiratory allergies), principally the epicutaneous (in food allergy),<sup>35</sup> intravenous (in drug-, biologics- and hormone allergy<sup>36</sup>), intralymphatic<sup>37</sup> and oral routes are possible.<sup>38</sup> The adjuvant choice may be decisive for optimally targeting the allergens to the lymphoid organs depending on the route of administration. Adjuvant formulations for subcutaneous, mucosal and percutaneous AIT applications presently addressed in registered clinical trials and listed in the official databases EudraCT and ClinicalTrials.gov are presented in Table 3. The overview makes clear that most SCIT trials with allergen extracts, as well as clinical trials with allergoids, hypoallergens and fusion proteins, use aluminium salts as adjuvants.

In terms of mucosal applications (SLIT, oral and intranasal) and epicutaneous AIT, most preparations in clinical practice do not contain adjuvants. Notably, there is increasing activity in introducing various adjuvant candidates for the mucosal route, like MPL, allergen-conjugates to adjuvants, virus-like particles (VLPs) or particulate allergen delivery systems such as chitin and cellulose, or for percutaneous application polylactic acid or silver particles in clinical trials (Table 3).

However, a plethora of alternative adjuvants and formulations of allergen extracts has been developed and are in the preclinical

pipeline awaiting introduction into clinical testing and practice (Table S1). They may change our way of performing AIT in the future. Immune-modifying platforms, such as allergen-displaying VLPs or cytosine-guanine dinucleotide (CpG)-motifs, adjuvants like MPL combined with Al(OH)<sub>3</sub> or with MCT, or spiking of molecular allergens with natural micronutrients, may improve the efficacy of AIT and more efficiently direct the immunological response towards a protective response or immunological tolerance.<sup>39</sup> Delivery systems, such as liposomes and microspheres as well as adjuvants such as Toll-like-receptor agonists [eg nonmethylated CpG-motifs derived from bacterial DNA], have been tested in clinical phase II and III trials demonstrating encouraging clinical effects<sup>40</sup> (Table S1). A high-density display of allergens on virus-like particles enhances the immunogenicity and at the same time seems to reduce potential anaphylactic reactions.<sup>41</sup>

The assessment of efficacy and safety of AIT adjuvants and formulations is hampered by the lack of head-to-head comparison studies, or inclusion of placebo controls in trials. Dose-finding studies are ongoing to fulfil the EMA-Guideline on the Clinical development of products for SIT for the Therapy of Allergic Diseases (CHMP/EWP/18504/2006).<sup>42</sup> These studies—together with ongoing activities of allergen standardization—will improve insight in efficacy and safety of allergen products and may pave the way for a transparent declaration of allergen dosages and extract composition, but also of adjuvants.

### 3 | ADJUVANTS IN MARKETING PRODUCTS

To enable a direct comparison among adjuvants and formulations currently used in AIT trade products on the market, a survey of the industry was performed specifically addressing the compositions for SCIT with grass pollen extracts. Leading pharmaceutical companies with marketed grass pollen products were approached by letters in November 2017 and asked to fill-in the supplied Tables to be published in this position paper of EAACI. Responses filled-in in the tables (Table 2 and Table S2) were gathered between December 2017 and March 2018, approved once more by the companies in December 2019, and were included in exactly the form as stated by the companies in the tables. All industry representatives supplying the data were informed about our parallel request to all competing companies. Eight of 11 approached companies responded and listed single to several products, totalling 18: AllergoPharma (Allergovit®), ALK (Alutard SQ; ALK7/Start SQ; Pangramin Ultra; Aquagen 100), Allergy Therapeutics (Pollinex® Grass, TA Graser top, MATA PFS; Pollinex® Quattro Grass, Tyrosine TU top Grass), HAL Allergy BV (Purethal® grasses), LETI (Depigoid grass; Depigoid Phleum), LOFARMA SpA (LAIS-in), ROXALL (CLUSTOID; Deposit; Allergovac Depot; Allergovac Polimerizado), STALLERGENES (Alustal®; Phostal®), as collectively illustrated in Table 2. ANERGIS SA, ASIT biotech and Biomay AG, at the time of the survey, had no grass pollen product on the market.

The classical adjuvant Al(OH)<sub>3</sub> was used in 12 of 18 listed grass pollen SCIT products, calcium phosphate (CaP) in two, MCT in three



**TABLE 2** Detailed list on product information for subcutaneous AIT products by industry

Industry	Brand name of product	Market area	Chemistry of the adjuvant	
			Chemical name	Synonyms/abbreviations
Allergopharma	Allergovit Grasses	Europe	Aluminum-hydroxide	n.disc.
ALK	Alutard SQ	n.disc.	Aluminium hydroxide, Sodium chloride Sodium hydrogen bicarbonate Phenol, water for injections	n.disc.
ALK	ALK7/Start SQ		Aluminium hydroxide, Sodium chloride Sodium hydrogen bicarbonate, Phenol	n.disc.
ALK	Pangramin Ultra	n.disc.	Aluminium hydroxide Sodium chloride Sodium hydroxide/ Hydrochloric acid Phenol Water for injections	n.disc.
ALK	Aquagen SQ	n.disc.	Mannitol Water for injections	n.disc.
Allergy Therapeutics	Pollinex Grass, TA Graser top, MATA PFS	globally available	Microcrystalline Tyrosine	MCT, L-tyrosine
Allergy Therapeutics	Pollinex Quattro Grass	globally available	Monophosphoryl Lipid A	MPL, MPL-A
Allergy Therapeutics	Pollinex Quattro Grass	globally available	Microcrystalline Tyrosine	MCT, L-tyrosine
Allergy Therapeutics	Tyrosine TU top Grass	globally available	Microcrystalline Tyrosine	MCT, L-tyrosine
HAL Allergy BV	Purethal Grasses	Europe	Aluminium hydroxide	Aluminic acid; Aluminic hydroxide; Aluminium(III) hydroxide; Aluminium hydroxide; Aluminum trihydroxide; Hydrated alumina; Orthoaluminic acid
LETI	Depigoid grass	n.disc.	Aluminium hydroxid	Alhydrogel
LETI	Depigoid Phleum	n.disc.	Aluminium hydroxid	Alhydrogel
LOFARMA SpA	LAIS-in Grass	Europe	Calcium phosphate	n.disc.
ROXALL	CLUSTOID	Germany-Austria-Italy	Aluminium hydroxide	Alhydrogel 2%
ROXALL	Deposit	Germany	Aluminium hydroxide	Alhydrogel 2%
ROXALL	Allergovac depot	Spain-Portugal-Italy	Aluminium hydroxide	Alhydrogel 1.3%
ROXALL	Allergovac Polimerizado	Spain-Portugal-Italy	Aluminium hydroxide	Alhydrogel 1.3%
STALLERGENES	Alustal®	n.disc.	Aluminium hydroxide	n.disc.
STALLERGENES	Phostal®	n.disc.	Calcium phosphate	n.disc.

and MPL in one (Figure 2A). Further, mannitol was contained in one product, phenol in three, which serve as stabilizers rather than adjuvants.

The number of injections depended on the schedules (3-5 years) and ranged from n = 18-63 (mean n = 30) in formulations with Al(OH)<sub>3</sub> (Table S2), between n = 39-63 (mean 41) in one of the two

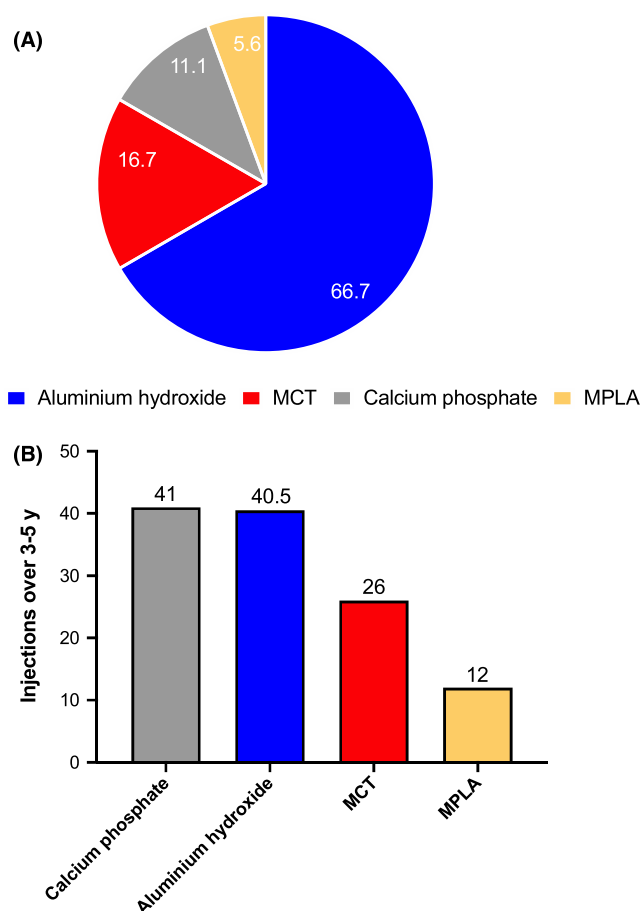
products adjuvanted with CaP, between n = 18-34 (mean n = 21) for products with MCT, and n = 12 for the single product adjuvanted with MPLA (Figure 2B; Table S2).

In most cases, the ratio of allergen:adjuvant is not declared or not known (Table 2; Table S2). In a single case, the precise ratio of group 5 allergens to adjuvant is revealed in the columns where

Linear chemical formula	Molecular weight	Physical properties of the adjuvant		
		Form	Density	Particle size
Al(OH) <sub>3</sub>	78.0 g/mol	n.discl.	n.discl.	n.discl.
Al(OH) <sub>3</sub>	n.discl.	n.discl.	n.discl.	n.discl.
Al(OH) <sub>3</sub>	n.discl.	n.discl.	n.discl.	n.discl.
Al(OH) <sub>3</sub>	n.discl.	n.discl.	n.discl.	n.discl.
n.discl.	n.discl.	n.discl.	n.discl.	n.discl.
C <sub>9</sub> H <sub>11</sub> NO <sub>3</sub>	181.19 Da	Crystalline	n.discl.	20 µm
C <sub>94</sub> H <sub>176</sub> N <sub>2</sub> O <sub>22</sub> P <sub>1</sub> (A)	1715 <sup>†</sup> Da	Micelle Formulation	n.discl.	<144 nm
C <sub>9</sub> H <sub>11</sub> NO <sub>3</sub>	181.19 Da	Crystalline	n.discl.	20 µm
C <sub>9</sub> H <sub>11</sub> NO <sub>3</sub>	181.19 Da	Crystalline	n.discl.	20 µm
Al(OH) <sub>3</sub>	78.0 g/mol	white amorphous powder	2.42 g/cm <sup>3</sup>	n.discl.
Al(OH) <sub>3</sub>	78.0 g/mol	depigmented, glutaraldehyde polymerized, chemically modified allergenic extract of Phleum pratense; Hydrogel (white gelatinous precipitate)	n.discl.	n.discl.
Ca <sub>3</sub> (PO <sub>4</sub> ) <sub>2</sub>	310 g/mol	carbamyated allergoid (potassium cyanate) adsorbed on gel of Calcium phosphate	n.k.	about 100 nm
Al(OH) <sub>3</sub>	78.0 g/mol	Hydrogel (white gelatinous precipitate), Fibrous primary particles	2.42 g/cu cm	1-10 µm
Al(OH) <sub>3</sub>	78.0 g/mol	Hydrogel (white gelatinous precipitate), Fibrous primary particles	2.42 g/cu cm	1-10 µm
Al(OH) <sub>3</sub>	78.0 g/mol	Hydrogel (white gelatinous precipitate), Fibrous primary particles	2.42 g/cu cm	1-10 µm
Al(OH) <sub>3</sub>	78.0 g/mol	Hydrogel (white gelatinous precipitate), Fibrous primary particles	2.42 g/cu cm	1-10 µm
Al(OH) <sub>3</sub>	78 g/mol	n.discl.	n.discl.	n.discl.
Ca <sub>3</sub> (PO <sub>4</sub> ) <sub>2</sub>	310 g/mol	n.discl.	n.discl.	n.discl.

we requested mg/mg declaration. The nomination of major allergens is advantageous as allergen extracts also contain non-protein compounds and nonallergens which do not contribute to the specific activity of the extract. Therefore, instead of whole protein, or weight-by-volume (Noon unit), the protein nitrogen unit (PNU; quantity of nitrogen extractable from 1 µg of pollen)

was introduced. Today, measures reflecting the biological activity of the extracts, such as histamine equivalent in prick testing (HEP), biologic unit (BU) or bioequivalent allergen units (BAU) have been suggested for optimization of allergen standardization.<sup>43</sup> It is, however, challenging to determine this activity for allergoids. The need of consistent quality in manufacturing for reliable



**FIGURE 2** Adjuvants in grass pollen AIT marketed in Europe. A) Percentage of products using  $\text{Al}(\text{OH})_3$ , MCT (alone), CaP or MPLA as adjuvant in grass AIT; B) Average number of injections with grass pollen AIT products recommended by the industry for administration schemes over 3-5 years (data from Table S2)

composition of allergen extracts in terms of major and minor allergens is increasing and supported by novel standardization methods.<sup>44</sup>

## 4 | ALUMINIUM COMPOUNDS

Aluminium hydroxide is the most widely used adjuvant for SCIT introduced since 1937, and aluminium and its chemical derivatives strongly support the immunogenicity of antigens.<sup>45,46</sup> Since it is the oldest adjuvant in AIT, most facts, figures and toxicity studies are available for  $\text{Al}(\text{OH})_3$ . Mechanisms involved include both a depot effect (ie slow release of the allergen, formulation of the allergen as particles to target antigen-presenting cells (APCs)) as well as interaction with the innate immune system: for example by stimulating the release of damage-associated molecular patterns (DAMPs),<sup>47</sup> by activating inflammatory DCs<sup>48</sup> or by metabolic reprogramming DCs,<sup>30</sup> while the previously reported dependence from inflammasome activation<sup>32</sup> recently was disputed.<sup>33</sup> More than 90% of all registered AIT products contain  $\text{Al}(\text{OH})_3$  in which the European Pharmacopoeia limits the aluminium content to 1.25 mg per parenteral dose.<sup>49</sup> The products currently registered (in

Germany) contain 0.113 to 1.135 mg/mL  $\text{Al}(\text{OH})_3$ , during up dosing and maintenance phase of SCIT. The therapeutic allergens are adsorbed to the adjuvants and  $\text{Al}(\text{OH})_3$  is characterized by a high degree of insolubility; this is actually a wanted effect since it results in a depot of the therapeutic allergen and increases the therapeutic success of AIT. The consequences are slow resorption and delayed bioavailability of the antigen. A study in rabbits using radioactive-labelled  $\text{Al}(\text{OH})_3$  demonstrated that within 28 days, 17% of the intramuscularly applied  $\text{Al}(\text{OH})_3$  was resorbed and 6% was excreted through the kidney.<sup>50</sup> A maximal concentration of 2  $\mu\text{g/L}$  of aluminium was observed in plasma. In one study, rabbits were subjected to 20 subcutaneous applications of aluminium lactate.<sup>51</sup> The *no observed effect level* (NOEL) was calculated to be 0.7 mg/kg per day. Interspecies extrapolation yielded a human equivalent dose of 23 mg aluminium for a 70-kg adult, which is more than 20-fold higher than the aluminium dose in a single shot in available therapeutic allergen preparations. Presently, novel in vitro methods are developed to test the toxicity of aluminium,<sup>52,53</sup> for instance the Paul Ehrlich-Institute (PEI, Langen, Germany) develops toxicokinetic models in vitro, in silico and in rats to determine intramuscular absorption of  $\text{Al}(\text{OH})_3$  for a risk prediction in humans.<sup>54,55</sup>

Among all pharmaceutical, occupational and consumer exposures potentially representing a health risk, the primary source of aluminium exposure in humans is the food.<sup>56</sup> There is a large inter-regional variation in the daily aluminium uptake, and a range between 0.2 and 1.5 mg/kg per week was calculated for adults. For children, a maximal dose of 0.7-2.3 mg/kg per week was reported by the European Food Safety Authority in a news release.<sup>57</sup> The health risk of aluminium originating from food has been evaluated several times by international experts including the Joint FAO-WHO Expert Committee on Food Additives (JECFA) and the AFC Panel (panel on food additives flavourings processing aids and materials in contact with food) of the EFSA.<sup>58,59</sup> EFSA calculated the *tolerable weekly intake* (TWI) of aluminium from all food sources at 1 mg/kg body weight per week.<sup>58</sup>

Although most of the aluminium is eliminated through the kidney, this is a slow process and due to the long half-life, a net-accumulation occurs. The lifelong body burden of aluminium is about 1%-2% of the resorbed dose, which is estimated as 5-60 mg of aluminium,<sup>60,61</sup> and with a higher risk in certain occupations.<sup>59</sup> Most of the aluminium is stored in the skeletal system, and about 1% is stored in the brain.<sup>62,63</sup> During a regular 3-year AIT cycle consisting of 8 applications per year, and with an allergen containing 0.5 mg aluminium per dose, an estimated total dose of 12-mg aluminium is administered. Calculating conservatively 2% retention, this would result in a lifelong accumulating dose of 0.24 mg aluminium from AIT. Table S2 illustrates differences in AIT regimens recommended by different providers.

The following aspects need to be considered

- The most known **local reactions** are the development of granuloma. This is dependent on the type of alum and extracts and the application.<sup>64,65</sup>
- **Sensitization.** Contact allergies to aluminium are rare,<sup>66-68</sup> but delayed type hypersensitivity may play a role in granuloma formation.<sup>64</sup>



- There is a debate that  $\text{Al}(\text{OH})_3$  may increase the allergy risk to the adsorbed allergen.<sup>69</sup> This is primarily based on animal models where  $\text{Al}(\text{OH})_3$  is used as a Th2 adjuvant. However, it is difficult to extrapolate from the mouse to the human situation. Vaccinated patients uncommonly develop an IgE-mediated allergic response to the vaccine-antigen,<sup>70,71</sup> except perhaps food allergens.<sup>72</sup> No evidence was reported that typical childhood vaccines such as M. bovis Bacille Calmette-Guerin, pertussis, influenza, measles, mumps, rubella or smallpox pose a risk for the later development of atopy<sup>73</sup> which, however, are mostly not adjuvanted with aluminium.<sup>71</sup> Furthermore, a long-term effect of  $\text{Al}(\text{OH})_3$  containing AIT, like with other adjuvants, is the induction of an IgG response (mostly IgG1, IgG4, much less IgG2 and 3) with a relative reduction of respective IgE antibodies.<sup>2,74,75</sup>
- **Acute toxicity.** As a consequence of high aluminium exposure symptoms of acute toxicity including neurotoxic effects (encephalopathy), bone marrow effects (anaemia), and on reproduction have been extensively studied in animal models. In humans, acute toxicity was particularly observed in patients with chronic kidney disease following long-lasting haemodialysis; this syndrome is known as *dialysis encephalopathy syndrome* (DES) and occurred particularly in the 1970s due to exorbitant aluminium uptake from the use of aluminium in the dialysis bath. Patients reached plasma levels between 200 and 500  $\mu\text{g/L}$  associated with onset of brain malfunction at  $>30 \mu\text{g/L}$ .<sup>62,65</sup> There have been no pharmacovigilance signals for acute toxicity linked to AIT.
- **Long-term toxicity.** There is a debate about the development of breast cancer, Alzheimer's disease, multiple sclerosis, autoimmunity<sup>76,77</sup> and other diseases in the context of aluminium burden. The German Institute of Risk Assessment (BfR) could not detect a relationship between the increase of aluminium intake from foods, medication, or cosmetic agents and the development of Alzheimer's disease,<sup>78</sup> while a recent meta-analysis determined a 71% increased risk (OR: 1.71, 95% confidence interval (CI), 1.35-2.18).<sup>79</sup> The use of newer staining methods like Lumogallion<sup>80</sup> has demonstrated to be useful to trace aluminium in tissues and may contribute to the necessary collection of more evidence.
- As much more data and studies are available for  $\text{Al}(\text{OH})_3$  than for any other adjuvant in AIT (which need to be studied in more detail), the detailed description of current knowledge on  $\text{Al}(\text{OH})_3$  may give

**TABLE 3** The clinical pipeline of adjuvants in allergen specific immunotherapy: registered clinical trials. A systematic review of the literature was performed in PubMed in 06/2018 for the preclinical trials using the terms “delivery system,” “adjuvant” and “allergen,” and by search of databases such as European clinical trials database EudraCT and ClinicalTrials.gov, using the term “allergy” and restricting to intervention trials

Type of Adjuvant	Classification	Allergen formulation	Route	No. of studies	Phase
Mineral Salts	Aluminium salts	Allergen extracts	SCIT	>40	2/3/4
		Allergoids	SCIT	2	2
		Allergen fusion Proteins	SCIT	4	2
		Hypoallergens	SCIT	2	2/3
		VLPs displaying allergen molecules	SCIT	1	2b
	Calcium phosphate	Allergen extracts	SCIT	2	4
Amino acids	Tyrosine	Allergen extracts, and Allergoids	SCIT	>15	1/2/3/4
TLR activators	TLR4 agonist MPL	Allergen extracts, Allergoids	SCIT	>15	1/2/3
	CpG ODN	Allergen extracts	SCIT	1, withdrawn	2
	TLR9 agonist QbG10	Allergen extracts	SCIT	4	1/2
Conjugated	Mannan	Allergoid	SCIT	2	2
Adjuvanted mucosal applications					
TLR activator	MPL	Allergen extract	SLIT	1	1
Conjugate	Mannan	Allergoids	SLIT	2	2
Microparticles	Cellulose	Allergen extracts	intranasal, SLIT	1	2/3
	Chitin	Allergen extracts	intranasal	1	1/2
Adjuvanted applications via the skin					
Microparticles	PLA	Allergen extracts	epicutaneous	1	1
Microparticles	Silver	Allergen extracts	epicutaneous	1	2

Abbreviations: Allergoids, Allergen extracts being polymerized by glutaraldehyde treatment, carbamylated or conjugated to mannan; CpG ODN, cytosine-phosphate-guanine oligodeoxynucleotides; MPL, monophosphoryl lipid A; PLA, polylactic acid; SCIT, subcutaneous allergen-specific immunotherapy; SLIT, sublingual allergen-specific immunotherapy; VLPs, virus-like particles.

the impression of an unfavourable benefit risk balance as an adjuvant, however no definite conclusions can be drawn at this point in time. Recent data derived from a model for aluminium toxicokinetics in rats give hope that individual vaccinations also in human tissue may not lead to measurable changes in the aluminium load.

- After several years of subcutaneous immunotherapy, a substantial, but clinically not relevant increase in the aluminium concentration in the bone has to be expected. Reliable extrapolations from results in rats to humans will be possible with the help of a physiology-based model under development. However, the aluminium toxicity data combined with manifold repeated injections of  $\text{Al}(\text{OH})_3$  in AIT (see Table S2), prompt us to carefully monitor the known and emerging pros and cons (of all adjuvants). Many vaccines (eg diphtheria, tetanus, pertussis, hepatitis B, pneumococcal and meningococcal vaccines) contain  $\text{Al}(\text{OH})_3$ , because an effective vaccination would not be possible without this adjuvantation. The authors do not question the usefulness of these vaccines in principle, are convinced of the survival benefit for mankind and reject any ongoing anti-vaccine discussion.

## 5 | MONOPHOSPHORYL LIPID A

MPLA, precisely 3-O-desacyl-4'-monophosphoryl lipid A (MPL®), is a low-toxicity derivative of the lipid A region of lipopolysaccharide (LPS), that retains the immunologically active lipid A portion of the parent molecule. While the toxicity associated with LPS prohibits its clinical use, MPL has been developed as a vaccine adjuvant in anti-infectious, anti-cancer vaccines<sup>81</sup> (for instance, MPL is contained in the FDA- and EMA-approved marketed Human Papilloma Vaccine by GSK) and in AIT, allowing lower injection numbers mimicking rather the vaccine approach.

MPL is extracted from lipopolysaccharide (LPS or endotoxin) produced by the Re mutant of a rough strain *Salmonella minnesota* R595. Lipid A, a disaccharide with fatty acid side chains, is the component responsible for the endotoxic activity of LPS. Removal of one phosphate group from lipid A produces MPL (*alias* MPLA) which has reduced toxicity while retaining the ability to stimulate the immune system via TLR4. Synthetic lipid A (MPLAs) from *E coli* is produced synthetically.

MPL in mouse studies<sup>82</sup> skews the immune response towards Th1 and Treg pathways, and it has been suggested that MPL improves vaccine immunogenicity by enhancing APC maturation. MPL, like CpG-ODN, imidazoquinolines and adenine derivatives acting via innate sensors represent improvements in AIT by interfering with pathogenic Th2 cells and promoting Th1 differentiation.<sup>83</sup>

Both LPS and MPL are TLR4 agonists. TLR signalling is involved in activating innate and adaptive immune responses and plays a critical role in inflammation-induced diseases. Dysregulation of this signalling pathway can result in disturbance of epithelial layer homeostasis, caused by chronic inflammation and excessive repair responses. MPL and several other agents have been approved for anti-cancer vaccines as there is now substantial evidence for the benefit of targeting of this pathway in cancer.<sup>84</sup>

LPS and MPLA signal through TLR4 which has two different TLR adaptors, MyD88 and TRIF. The reduced toxicity of MPLA is attributed to the preferential recruitment of TRIF upon TLR4 activation, resulting in decreased induction of inflammatory cytokines.

MPLAs activate TLR4 but do not activate TLR2 reflecting the high purity of this synthesized compound. MPLAs contain 6 fatty acyl groups, while MPL purified from bacteria contains a mixture of 5, 6 and 7 acyl lipid A.

Combining distinct immune stimulants in adjuvants can even further improve the quality of the immune response to the vaccine. A unique mechanism of molecular and cellular synergies between MPL, and a saponin, QS-21, the constituents of the Adjuvant System AS01, has been reported.<sup>85</sup> AS01 is part of the first malaria vaccine candidate and a herpes zoster vaccine that has recently received marketing authorization in a centralized procedure throughout the EU (21.3.2018). This mechanism, previously described for infections, illustrates how adjuvants trigger naturally occurring pathways and may improve the efficacy of AIT. Vice versa, the adsorption of allergoids and MPL to MCT in formulations for use in AIT suggested that it could be an alternative adjuvant depot for some infectious disease antigens.<sup>86</sup>

Likewise, attempts were made to combine MPL with aluminium salts in the adjuvant system AS04 in papilloma vaccines.<sup>87</sup> More recently, it was demonstrated that combining MPL plus aluminium salts, or MPL plus muramyl-dipeptide (MDP), a NOD-like receptor (NLR) agonist exerted additive effects on the magnitude and quality of humoral responses towards HIV envelope antigens.<sup>88</sup>

Due to the dual action of stimulating the immune system, a tyrosine-adsorbed and MPL-adjuvanted AIT was clinically effective after only four injections given preseasonally<sup>89</sup> and, in another study, contributed to the control of asthma during the pollen season.<sup>90</sup> An ultra-short course of ragweed MATA MPL (short ragweed pollen allergoid adsorbed to L-tyrosine + MPL) was efficacious in reducing allergy symptoms in patients with seasonal allergic rhinitis and was well tolerated.<sup>91</sup> Ultra-short grass pollen AIT adjuvanted with MPL achieved specific bronchial tolerance as well as increased IgG4 levels (median before SCIT 0.34-11.4 kU/L after SCIT), whereas the total and specific IgE levels remained unchanged.<sup>92</sup> Especially in the presence of MPL, the allergenicity of an employed allergoid was sharply reduced when compared to the native allergen, while its immunogenicity was largely retained.<sup>93</sup> Booster AIT, using MCT-adsorbed allergoids containing the adjuvant MPL, effectively prevented reoccurrence of symptoms in patients with grass pollen-induced allergic rhinoconjunctivitis who had completed a successful course of any grass pollen AIT at least 5 years before enrolment, compared to control patients who received symptomatic medication.<sup>94</sup>

The following aspects need to be considered

- The most common adverse effects of MPL-adjuvanted AIT are transient and local, such as redness, swelling and pruritus at the injection site.<sup>95</sup>
- However, a case of anaphylactic shock after administration of a pollen extract allergoid adsorbed onto L-tyrosine adjuvanted with MPL-4 has been described.<sup>96</sup>

- Since MPL was introduced only in 1999, more data are needed to reveal any potential toxicity.

Overall, detoxified lipopolysaccharide (MPL-A), MPLAs, CpG-ODNs, imidazoquinolines and adenine derivatives acting via innate sensors represent improvements in therapeutic vaccinations for allergy as they are able to interfere with pathogenic Th2 cells with eventual induction of Th1 differentiation and enhancing IgG responses.<sup>83,97</sup> Furthermore, the use of explicit anti-Th2 adjuvants like MPL<sup>89,98</sup> instead of adjuvants like aluminium compounds<sup>69</sup> might well help to improve current AIT protocols, potentially also of SLIT.<sup>99</sup>

## 6 | MICROCRYSTALLINE TYROSINE

Tyrosine is an amino acid that in crystalline form can be used as a biodegradable adjuvant with depot effect. In a mouse model, MCT was recently compared head-to-head with  $\text{Al}(\text{OH})_3$ ,<sup>33</sup> where it induced fewer anaphylactic reactions. In the same paper, the immune mechanism of MCT as an adjuvant was addressed for the first time. In analogy to  $\text{Al}(\text{OH})_3$ , MCT provoked caspase-dependent secretion of IL-1 $\beta$  from cultured human monocytes, and in a model with immune-signalling-deficient and TCR-transgenic mice, it was concluded that the inflammasome activation did not affect functionally the innate inflammatory or specific immune responses. In contrast to the LPS-derived MPL, MCT does not act via TLR4 signalling.<sup>33</sup>

MCT induced in mice less IL-4 and IgE formation than aluminium. It is also applied safely in preclinical models of malaria vaccines.<sup>100,101</sup> Furthermore, MCT has been shown to be beneficial in influenza vaccination when compared to  $\text{Al}(\text{OH})_3$ ,<sup>102</sup> where it enhanced antibody responses towards this vaccine.

When AIT effects on IgG4 induction were compared among the nonadjuvanted US product (Hollister-Stier®, Spokane, WA, US), and adjuvanted European products either using MCT (Tyrosine®, AllergyTherapeutics, UK) or  $\text{Al}(\text{OH})_3$  (Novo-Hellisen®, AllergoPharma, Reinbeck, Germany) (Park), the US product showed the highest potency in inducing IgG4.<sup>103</sup> However, in this study only patients without adverse side effects were included, thereby precluding any conclusions about simultaneous safety.<sup>103</sup>

The following aspects need to be considered

- At present, and since its introduction into AIT in 1970, there are no specific safety concerns known for MCT.
- It can be anticipated that this fully biodegradable adjuvants will also in future studies not reveal side effects.

## 7 | CALCIUM PHOSPHATE

As an adjuvant calcium phosphate was developed 40 years ago as an adjuvant.<sup>104</sup> It has been included in vaccines against various infectious diseases such as diphtheria, tetanus, pertussis and poliomyelitis. It was shown to be well tolerated in humans, and even more

efficacious than  $\text{Al}(\text{OH})_3$  when used as part of a booster vaccine for DT (diphtheria/tetanus).<sup>105</sup>

Approved by the World Health Organization, CaP was further used in combination with allergens for hyposensitization purposes, based on the observation that it induces IgG, but not IgE responses. CaP is currently commercially available in Europe as a component of subcutaneous allergy vaccines in combination with grass pollen or mite extracts.<sup>106,107</sup> The aqueous allergen extracts are adsorbed onto the particulate CaP microcrystals. Allergen loading is thus thought to occur by passive adsorption, but also following encapsulation during particle formation. As a well-tolerated adjuvant, CaP has been proposed as a substitute to aluminium-based adjuvants in allergic humans and dogs.<sup>108</sup> A review of the present evidence suggests that CaP particles reintroduce a more balanced immune response when compared with aluminium salts, known to elicit a Th2-biased humoral immune response.<sup>105,82</sup>

Mechanisms of CaP in AIT include a depot effect with a slow release of the allergen. In addition, the adsorption of allergens onto CaP microcrystals as particles also facilitates the uptake by phagocytic cells (ie monocytes, macrophages, DCs), thereby enhancing the immunogenicity of protein allergens, with the induction of strong IgG responses.<sup>109</sup> As a mineral adjuvant, CaP also induces the NALP3 inflammasome, resulting in the secretion of IL-1 $\beta$  and IL-18 pro-inflammatory mediators.

The following aspects need to be considered

- CaP is a compound present in many living organisms. As such, it is biocompatible and well tolerated by most patients. Common side effects include local reactions at the site of administration.
- More data are needed to exclude any potential toxicity.
- More studies are needed to support its efficacy as compared to other adjuvants.

## 8 | CONCLUSION

AIT is applied in patients who are hypersensitive to an allergen and at risk for adverse immediate type reactions. However, quality, efficacy, safety and tolerability of AIT as the only disease-modifying treatment option is key. All reviewed types of marketed adjuvants precipitate the allergen as a depot at the injection site thereby reducing the risk for systemic anaphylaxis, and are also prolonging their availability for the immune cells.

The Task Force's review further revealed that, at present, only a limited number of adjuvants are applied in AIT vaccines. In marketed formulations, aluminium compounds are predominant in Europe albeit the fact that aspects concerning health safety of aluminium have been controversially discussed. The immune mechanisms of the adjuvants,  $\text{Al}(\text{OH})_3$ , MPL and MCT have only been addressed in recent years (while others are still missing) and explain their reported contrasting immune profile: aluminium, MCT and MPL induce high levels of blocking antibodies and regulatory T cells; aluminium hydroxide initially

boosts a Th2 response, while MPL and MCT induce early skewing towards a Th1 response; all adjuvants induce varying inflammation suggesting a hierarchy of biocompatibility MCT > CaP>MPL > Al(OH)<sub>3</sub>.

The preclinical pipeline is filled with interesting novel options in terms of adjuvants and carrier systems, and immune-modifying molecules, being more biocompatible and allowing development of improved immunization schedules with greater comfort for the patient. All reported strategies are of the highest importance to improve the insufficient adherence of patients in AIT independent of route of administration as SCIT or SLIT, resulting in only 18% of users reaching the minimal 3-year course duration in an earlier study,<sup>110</sup> while in studies with other products adherence rates up to 50% were reported,<sup>111,112</sup> The discussion is ongoing whether shorter treatment regimens could improve adherence,<sup>113</sup> as most dropouts (with aluminium or tyrosin-adjuvanted products) occurred already in the first year,<sup>111</sup> paradoxically with cluster build-up and rush schemes, younger age and, interestingly, to longer disease duration.<sup>114</sup> In SLIT, forgetfulness may be the most important reason for dropouts.<sup>115</sup> Overall, adherence is a severe problem in all of the currently marketed AIT products, underlining the need for optimizing AIT with novel adjuvants and enhanced efficacy towards true vaccine concepts.

## ACKNOWLEDGMENTS

The Task Force was financed by the European Academy for Allergy and Clinical Immunology (EAACI). The authors would like to thank EAACI for financial support in the development of this position paper.

The authors would like to thank the following leading persons from industry for excellent cooperation, providing data given in Table 2 and Table S2 (alphabetically): AllergoPharma: Dr Christoph Willers MD, PhD, MBA; ALK: Jørgen Nedergaard Larsen, PhD; Allergy Therapeutics: Prof. Dr Matthias Kramer; HAL Allergy BV: Dr Dirk Jan Opstelten; LETI: Jeronimo Carnes; LOFARMA SpA: Dr Enrico Compalati, MD, PhD; ROXALL: Dr Jenny Uhlig; STALLERGENES: Dr Stratos Karagiannis.

The authors acknowledge support by the Austrian Science Fund FWF grants F4606-B28 to EJJ; Harald Renz is supported by Deutsche Zentrum für Lungenforschung (DZL, German Lung Center, no. 82DZL00502) and Deutsche Forschungsgemeinschaft (DFG)-funded SFB 1021.

## CONFLICT OF INTERESTS

All authors have read and approved the position paper. Any potential conflicts of interests are listed here. JJE: Erika Jensen-Jarolim declares inventorship in patents on allergen immunotherapy formulation with Biomedical International R+D, Vienna, Austria, of which she is shareholder. She received honoraria for presentations from Allergy Therapeutics, AllergoPharma, Bencard, Meda, Roxall, ThermoFisher, and consulted previously for MediGene, Germany, Novartis, for Allergy Therapeutics and Dr Schär. BM: Martin Bachmann declares inventorship in patents on allergen immunotherapy drugs and formulation with Saiba GmbH, Pfäffikon Switzerland and Hypopet AG, Zürich, Switzerland of which he is shareholder. He received honoraria for presentations from Allergy Therapeutics. BS: Sergio Bonini

has no disclosures. JL: Lars Jacobsen did not declare any COI. JM: Marek Jutel reports personal fees from ALK-Abello, personal fees from Allergopharma, personal fees from Stallergenes, personal fees from Anergis, personal fees from Allergy Therapeutics, personal fees from Circassia, personal fees from Leti, personal fees from Biomay, personal fees from HAL, during the conduct of the study; personal fees from Astra-Zeneca, personal fees from GSK, personal fees from Novartis, personal fees from Teva, personal fees from Vectura, personal fees from UCB, personal fees from Takeda, personal fees from Roche, personal fees from Janssen, personal fees from Medimmune, personal fees from Chiesi, outside the submitted work. KL: Ludger Klimek reports grants and personal fees from ALK Abelló, Denmark, personal fees from MEDA, Sweden, grants and personal fees from Novartis, Switzerland, grants and personal fees from Allergopharma, Germany, grants and personal fees from Bionorica, Germany, personal fees from Boehringer Ingelheim, Germany, grants and personal fees from GSK, Great Britain, grants and personal fees from Lofarma, Italy, grants from Biomay, Austria, grants from HAL, Netherlands, grants from LETI, Spain, grants from Roxall, Germany, grants from Bencard, Great Britain, outside the submitted work. MV: Vera Mahler reports within the last 3 years (prior to current position at PEI) personal fees (lecturing fees and honoraria as an expert in advisory boards) from ALK, Bencard/ATL; HAL Allergy and from Novartis/Leti; other (payments to institution (reimbursement for participation in clinical studies) from Allergopharma, DBV and Novartis; research grants from Novartis; nonfinancial support from European Academy of Allergy and Clinical Immunology outside the submitted work. MR: Dr Ralph Mösges reports personal fees from ALK, grants from ASIT biotech, personal fees from Allergopharma, personal fees from Allergy Therapeutics, grants and personal fees from Bencard, grants from Leti, grants, personal fees and nonfinancial support from Lofarma, nonfinancial support from Roxall, grants and personal fees from Stallergenes, grants from Optima, personal fees from Friulchem, personal fees from Hexal, personal fees from Servier, personal fees from Klosterfrau, nonfinancial support from Atmos, personal fees from Bayer, nonfinancial support from Bionorica, personal fees from FAES, personal fees from GSK, personal fees from MSD, personal fees from Johnson & Johnson, personal fees from Meda, personal fees and nonfinancial support from Novartis, nonfinancial support from Otonomy, personal fees from Stada, personal fees from UCB, nonfinancial support from Ferrero, grants from BitopAG, grants from Hulka, personal fees from Nuvo, grants from Ursapharm, outside the submitted work. MP: Philippe Moingeon has no disclosures. OHR: Robyn O'Hehir reports that she is a minority shareholder of two early stage biotechnology companies—Aravax Pty Ltd and Paranta Bio Pty Ltd (in respect of both of which she is a named inventor of the IP assets)—and as such may benefit in the future if the respective experimental medicines are approved for use. PO: Oscar Palomares reports research grants from Immunotek SL under public collaborative projects from Spanish Ministry (MINECO)/CDTI and from Novartis. Lectures fees from: Allergic Therapeutics, Amgen, AstraZeneca, Immunotek S.L, Novartis, Sanofi Genezyme and Stallergenes. Participation in advisory boards from Novartis and



Sanofi Genezyme. PfO: Dr. Pfaar reports grants and personal fees from ALK—Abelló, grants and personal fees from Allergopharma, grants and personal fees from Stallergenes Greer, grants and personal fees from HAL Allergy Holding B.V./HAL Allergie GmbH, grants and personal fees from Bencard Allergie GmbH/Allergy Therapeutics, grants and personal fees from Lofarma, grants from Biomey, grants from Circassia, grants and personal fees from ASIT Biotech Tools S.A., grants and personal fees from Laboratorios LETI/LETI Pharma, personal fees from MEDA Pharma/MYLAN, grants and personal fees from Anergis S.A., personal fees from Mobile Chamber Experts (a GA2LEN Partner), personal fees from Indoor Biotechnologies, grants from Glaxo Smith Kline, personal fees from Astellas Pharma Global, personal fees from EUFOREA, personal fees from ROXALL, personal fees from NOVARTIS, personal fees from SANOFI AVENTIS Pharma, outside the submitted work. RH: Harald Renz is supported by Deutsche Zentrum für Lungenforschung (DZL, German Lung Center, no. 82DZL00502) and Deutsche Forschungsgemeinschaft (DFG)-funded SFB 1021. RC: Claudio Rhyner has nothing to disclose. RWF: Franziska Roth-Walter declares inventorship in patents on allergen immunotherapy formulation with Biomedical International R+D GmbH, Vienna, Austria. RM: Michael Rudenko has no disclosures. SJ: Johannes Savolainen has no disclosures. SWC: Carsten Schmidt-Weber declares to have received grants from Leti, Bencard and AllergoPharma. THC: Claudia Traidl-Hoffmann reports personal fees (lecturing fees and honoraria as an expert in advisory boards) from Bencard, Lilly, Sanofi and Novartis; other (payments to institution, reimbursement for participation in clinical studies) from Danone Nutricia, Sebapharma and Assana Biosciences. KT: Thomas Kündig reports grants and personal fees from Bencard Allergie GmbH/Allergy Therapeutics, grants and personal fees from Cytos Biotechnology, grants and personal fees from AlleCure Corp., grants and personal fees from Saiba AG, grants and personal fees from HypoPet AG, grants and personal fees from EVAX AG, grants and personal fees from XBiotech Corp., advisory boards for Stallergenes, Novartis, Celgene, AbbVie. Grants from the Swiss National Science Foundation, InnoSuisse, OncoSuisse, EU funding bodies, and the EAACI.

## ORCID

Erika Jensen-Jarolim  <https://orcid.org/0000-0003-4019-5765>  
 Martin F. Bachmann  <https://orcid.org/0000-0003-4370-2099>  
 Marek Jutel  <https://orcid.org/0000-0002-6974-5700>  
 Vera Mahler  <https://orcid.org/0000-0001-6471-1811>  
 Ralph Mösges  <https://orcid.org/0000-0002-1928-810X>  
 Robyn E. O'Hehir  <https://orcid.org/0000-0002-3489-7595>  
 Oscar Palomares  <https://orcid.org/0000-0003-4516-0369>  
 Oliver Pfaar  <https://orcid.org/0000-0003-4374-9639>  
 Harald Renz  <https://orcid.org/0000-0003-0602-7215>  
 Claudio Rhyner  <https://orcid.org/0000-0003-3339-3923>  
 Franziska Roth-Walter  <https://orcid.org/0000-0001-5005-9228>  
 Michael Rudenko  <https://orcid.org/0000-0002-6065-9451>  
 Carsten B. Schmidt-Weber  <https://orcid.org/0000-0002-3203-8084>  
 Claudia Traidl-Hoffmann  <https://orcid.org/0000-0001-5085-5179>

Thomas Kündig  <https://orcid.org/0000-0003-3863-8766>  
 Johannes Savolainen  <https://orcid.org/0000-0002-2161-7443>

## REFERENCES

1. Akdis CA, Akdis M. Mechanisms of allergen-specific immunotherapy and immune tolerance to allergens. *World Allergy Organ J*. 2015;8(1):17.
2. Eifan AO, Shamji MH, Durham SR. Long-term clinical and immunological effects of allergen immunotherapy. *Curr Opin Allergy Clin Immunol*. 2011;11(6):586-593.
3. Głobińska A, Boonpiyathad T, Satitsuksanoa P, et al. Mechanisms of allergen-specific immunotherapy: diverse mechanisms of immune tolerance to allergens. *Ann Allergy Asthma Immunol*. 2018;121(3):306-312.
4. Jutel M, Agache I, Bonini S, et al. International consensus on allergy immunotherapy. *J Allergy Clin Immunol*. 2015;136(3):556-568.
5. Palomares O, Akdis M, Martin-Fontecha M, Akdis CA. Mechanisms of immune regulation in allergic diseases: the role of regulatory T and B cells. *Immunol Rev*. 2017;278(1):219-236.
6. van de Veen W, Stanic B, Wirz OF, Jansen K, Globinska A, Akdis M. Role of regulatory B cells in immune tolerance to allergens and beyond. *J Allergy Clin Immunol*. 2016;138(3):654-665.
7. Boonpiyathad T, Sokolowska M, Morita H, et al. Der p 1-specific regulatory T-cell response during house dust mite allergen immunotherapy. *Allergy*. 2019;74(5):976-985.
8. Boonpiyathad T, van de Veen W, Wirz O, et al. Role of Der p 1-specific B cells in immune tolerance during 2 years of house dust mite-specific immunotherapy. *J Allergy Clin Immunol*. 2019;143(3):1077-1086; e1010.
9. Gueguen C, Luce S, Lombardi V, Baron-Bodo V, Moingeon P, Mascarell L. IL-10 mRNA levels in whole blood cells correlate with house dust mite allergen immunotherapy efficacy. *Allergy*. 2019;74:2223-2226.
10. Ryan JF, Hovde R, Ghanville J, et al. Successful immunotherapy induces previously unidentified allergen-specific CD4+ T-cell subsets. *Proc Natl Acad Sci USA*. 2016;113(9):E1286-1295.
11. Gueguen C, Bouley J, Moussu H, et al. Changes in markers associated with dendritic cells driving the differentiation of either TH2 cells or regulatory T cells correlate with clinical benefit during allergen immunotherapy. *J Allergy Clin Immunol*. 2016;137(2):545-558.
12. Shamji MH, Kappen J, Abubakar-Waziri H, et al. Nasal allergen-neutralizing IgG4 antibodies block IgE-mediated responses: Novel biomarker of subcutaneous grass pollen immunotherapy. *J Allergy Clin Immunol*. 2019;143(3):1067-1076.
13. James LK, Till SJ. Potential mechanisms for IgG4 inhibition of immediate hypersensitivity reactions. *Curr Allergy Asthma Rep*. 2016;16(3):23.
14. Jensen-Jarolim E, Turner MC, Karagiannis SN. AllergoOncology: IgE- and IgG4-mediated immune mechanisms linking allergy with cancer and their translational implications. *J Allergy Clin Immunol*. 2017;140(4):982-984.
15. Bianchini R, Roth-Walter F, Ohradanova-Repic A, et al. IgG4 drives M2a macrophages to a regulatory M2b-like phenotype: potential implication in immune tolerance. *Allergy*. 2019;74(3):483-494.
16. Shamji MH, Kappen JH, Akdis M, et al. Biomarkers for monitoring clinical efficacy of allergen immunotherapy for allergic rhinoconjunctivitis and allergic asthma: an EAACI Position Paper. *Allergy*. 2017;72(8):1156-1173.
17. Pfaar O, Lou H, Zhang Y, Klimek L, Zhang L. recent developments and highlights in allergen immunotherapy. *Allergy*. 2018;73(12):2274-2289.
18. Zissler UM, Jakwerth CA, Gueth FM, et al. Early IL-10 producing B-cells and coinciding Th/Tr17 shifts during three year grass-pollen AIT. *EBioMedicine*. 2018;36:475-488.



19. Layhadi JA, Eguiluz-Gracia I, Shamji MH. Role of IL-35 in sublingual allergen immunotherapy. *Curr Opin Allergy Clin Immunol*. 2019;19(1):12-17.
20. Shamji MH, Layhadi JA, Achkova D, et al. Role of IL-35 in sublingual allergen immunotherapy. *J Allergy Clin Immunol*. 2019;143(3):1131-1142; e1134.
21. Yao Y, Wang Z-C, Wang N, et al. Allergen immunotherapy improves defective follicular regulatory T cells in patients with allergic rhinitis. *J Allergy Clin Immunol*. 2019;144(1):118-128.
22. Roth-Walter F, Schmutz R, Mothes-Luksch N, et al. Clinical efficacy of sublingual immunotherapy is associated with restoration of steady-state serum lipocalin 2 after SLIT: a pilot study. *World Allergy Organ J*. 2018;11(1):21.
23. Hoffmann HJ, Valovirta E, Pfaar O, et al. Novel approaches and perspectives in allergen immunotherapy. *Allergy* 2017;72(7):1022-1034.
24. Jutel M, Agache I, Bonini S, et al. International consensus on allergen immunotherapy II: Mechanisms, standardization, and pharmacoeconomics. *J Allergy Clin Immunol*. 2016;137(2):358-368.
25. Mahler V, Esch RE, Kleine-Tebbe J, et al. Understanding differences in allergen immunotherapy products and practices in North America and Europe. *J Allergy Clin Immunol*. 2019;143(3):813-828.
26. Cox L, Calderon MA. Subcutaneous specific immunotherapy for seasonal allergic rhinitis: a review of treatment practices in the US and Europe. *Curr Med Res Opin*. 2010;26(12):2723-2733.
27. Worm M, Rak S, Samoliński B, et al. Efficacy and safety of birch pollen allergoid subcutaneous immunotherapy: A 2-year double-blind, placebo-controlled, randomized trial plus 1-year open-label extension. *Clin Exp Allergy*. 2019;49(4):516-525.
28. Zielen S, Pluckhahn K, Akboga Y, Rieker-Schwiebacher J, Thieme U, Rosewich M. Fast up dosing with a birch allergoid is safe and well tolerated in allergic rhinitis patients with or without asthma. *Immunotherapy*. 2019;11(3):177-187.
29. Rauber MM, Wu HK, Adams B, et al. Birch pollen allergen-specific immunotherapy with glutaraldehyde-modified allergoid induces IL-10 secretion and protective antibody responses. *Allergy* 2019;74(8):1575-1579.
30. Benito-Villalvilla C, Soria I, Perez-Diego M, Fernandez-Caldas E, Subiza JL, Palomares O. Alum impairs tolerogenic properties induced by allergoid-mannan conjugates inhibiting mTOR and metabolic reprogramming in human DCs. *Allergy* 2019.[Epub ahead of print]
31. Ho NI, Huis in 't Veld LGM, Raaijmakers TK, Adema GJ. Adjuvants enhancing cross-presentation by dendritic cells: the key to more effective vaccines? *Front Immunol*. 2018;9:2874.
32. Kool M, Pétrilli V, De Smedt T, et al. Cutting edge: alum adjuvant stimulates inflammatory dendritic cells through activation of the NALP3 inflammasome. *J Immunol*. 2008;181(6):3755-3759.
33. Leuthard DS, Duda A, Freiburger SN, et al. Microcrystalline tyrosine and aluminum as adjuvants in allergen-specific immunotherapy protect from IgE-mediated reactivity in mouse models and act independently of inflammasome and TLR signaling. *J Immunol*. 2018;200(9):3151-3159.
34. Korsholm KS, Petersen RV, Agger EM, Andersen P. T-helper 1 and T-helper 2 adjuvants induce distinct differences in the magnitude, quality and kinetics of the early inflammatory response at the site of injection. *Immunology* 2010;129(1):75-86.
35. Bird JA, Sanchez-Borges M, Ansotegui IJ, Ebisawa M, Ortega Martell JA. Skin as an immune organ and clinical applications of skin-based immunotherapy. *World Allergy Organ J*. 2018;11(1):38.
36. Foer D, Buchheit KM, Gargiulo AR, Lynch DM, Castells M, Wickner PG. Progesterone hypersensitivity in 24 cases: diagnosis, management, and proposed renaming and classification. *J Allergy Clin Immunol Pract*. 2016;4(4):723-729.
37. Senti G, Freiburghaus AU, Larenas-Linnemann D, et al. Intralymphatic immunotherapy: update and unmet needs. *Int Arch Allergy Immunol*. 2019;178:141-149.
38. Aricigil M, Muluk NB, Sakarya EU, et al. New routes of allergen immunotherapy. *Am J Rhinol Allergy*. 2016;30(6):193-197.
39. Klimek L, Pfaar O, Bousquet J, Senti G, Kundig T. Allergen immunotherapy in allergic rhinitis: current use and future trends. *Expert Rev Clin Immunol*. 2017;13(9):897-906.
40. Pfaar O, Cazan D, Klimek L, Larenas-Linnemann D, Calderon MA. Adjuvants for immunotherapy. *Curr Opin Allergy Clin Immunol*. 2012;12(6):648-657.
41. Engeroff P, Caviezel F, Storni F, Thoms F, Vogel M, Bachmann MF. Allergens displayed on virus-like particles are highly immunogenic but fail to activate human mast cells. *Allergy* 2018;73(2):341-349.
42. Pfaar O, Bonini S, Cardona V, et al. Perspectives in allergen immunotherapy: 2017 and beyond. *Allergy* 2018;73(Suppl 104):5-23.
43. Jeong KY, Hong CS, Lee JS, Park JW. Optimization of allergen standardization. *Yonsei Med J*. 2011;52(3):393-400.
44. Bonertz A, Mahler V, Vieths S. Manufacturing and quality assessment of allergenic extracts for immunotherapy: state of the art. *Curr Opin Allergy Clin Immunol*. 2019;19(6):640-645.
45. Moingeon P. Adjuvants for allergy vaccines. *Hum Vaccin Immunother*. 2012;8(10):1492-1498.
46. Brunner R, Wallmann J, Szalai K, et al. Aluminium per se and in the anti-acid drug sucralose promotes sensitization via the oral route. *Allergy* 2009;64(6):890-897.
47. Hayashi T, Momota M, Kuroda E, et al. DAMP-inducing adjuvant and PAMP adjuvants parallelly enhance protective Type-2 and Type-1 immune responses to influenza split vaccination. *Front Immunol*. 2018;9:2619.
48. Kool M, Soullé T, van Nimwegen M, et al. Alum adjuvant boosts adaptive immunity by inducing uric acid and activating inflammatory dendritic cells. *J Exp Med*. 2008;205(4):869-882.
49. Allergen products. *Eur Pharmacopoeia* 90. 2017;1063(01):811-812.
50. Flarend RE, Hem SL, White JL, et al. In vivo absorption of aluminium-containing vaccine adjuvants using <sup>26</sup>Al. *Vaccine*. 1997;15(12-13):1314-1318.
51. Yokel RA. Toxicity of gestational aluminum exposure to the maternal rabbit and offspring. *Toxicol Appl Pharmacol*. 1985;79(1):121-133.
52. Zaitseva M, Romantseva T, Blinova K, et al. Use of human MonoMac6 cells for development of in vitro assay predictive of adjuvant safety in vivo. *Vaccine* 2012;30(32):4859-4865.
53. Hiradate Y, Sasaki E, Momose H, et al. Development of screening method for intranasal influenza vaccine and adjuvant safety in pre-clinical study. *Biologicals* 2018;55:43-52.
54. Weisser K, Stubler S, Matheis W, Huisinga W. Towards toxicokinetic modelling of aluminium exposure from adjuvants in medicinal products. *Regul Toxicol Pharmacol*. 2017;88:310-321.
55. Weisser K, Goen T, Oduro JD, Wangorsch G, Hanschmann KO, Keller-Stanislawski B. Aluminium toxicokinetics after intramuscular, subcutaneous, and intravenous injection of Al citrate solution in rats. *Arch Toxicol*. 2019;93(1):37-47.
56. Willhite CC, Karyakina NA, Yokel RA, et al. Systematic review of potential health risks posed by pharmaceutical, occupational and consumer exposures to metallic and nanoscale aluminum, aluminum oxides, aluminum hydroxide and its soluble salts. *Crit Rev Toxicol*. 2014;44(Suppl 4):1-80.
57. Authority EFS. EFSA advises on the safety of aluminium in food, 2008. <http://www.efsa.europa.eu/en/press/news/080715-0>
58. Authority EFS. Safety of aluminium from dietary intake, scientific opinion of the panel on food additives, flavourings, processing aids and food contact materials (AFC) (Published first, updated November 2009). *EFSA Journal*. 2008;2009:1-34.

59. World Health Organization G. Safety evaluation of certain contaminants in food. Prepared by the Sixty-fourth meeting of the Joint FAO/WHO Expert Committee on Food Additives (JECFA). *FAO Food Nutr Pap.* 2006;82:1-778.
60. Exley C. Comment on "The biological behaviour and bioavailability of aluminium in man" by N. D. Priest, *JEM*, 2004, 6, 375. *J Environ Monit* 2005;7(6):641-642; author reply 641-642.
61. Priest ND. The biological behaviour and bioavailability of aluminium in man, with special reference to studies employing aluminium-26 as a tracer: review and study update. *J Environ Monit.* 2004;6(5):375-403.
62. Alfrey AC. Aluminum metabolism. *Kidney Int Suppl.* 1986;18:S8-11.
63. Yokel RA, McNamara PJ. Aluminium toxicokinetics: an updated minireview. *Pharmacol Toxicol.* 2001;88(4):159-167.
64. Vogelbruch M, Nuss B, Korner M, Kapp A, Kiehl P, Bohm W. Aluminium-induced granulomas after inaccurate intradermal hyposensitization injections of aluminium-adsorbed depot preparations. *Allergy* 2000;55(9):883-887.
65. Wuthrich B, Gumowski PL, Fah J, et al. Safety and efficacy of specific immunotherapy with standardized allergenic extracts adsorbed on aluminium hydroxide. *J Investig Allergol Clin Immunol.* 2001;11(3):149-156.
66. Lopez S, Pelaez A, Navarro LA, Montesinos E, Morales C, Carda C. Aluminium allergy in patients hyposensitized with aluminium-precipitated antigen extracts. *Contact Dermatitis.* 1994;31(1):37-40.
67. Netterlid E, Hindsén M, Björk J, et al. There is an association between contact allergy to aluminium and persistent subcutaneous nodules in children undergoing hyposensitization therapy. *Contact Dermatitis.* 2009;60(1):41-49.
68. Netterlid E, Hindsén M, Siemund I, et al. Does allergen-specific immunotherapy induce contact allergy to aluminium? *Acta Derm Venereol.* 2013;93(1):50-56.
69. Jensen-Jarolim E. Aluminium in Allergies and Allergen immunotherapy. *World Allergy Organ J.* 2015;8(1):7.
70. Gruber C, Nilsson L, Björkstén B. Do early childhood immunizations influence the development of atopy and do they cause allergic reactions? *Pediatr Allergy Immunol.* 2001;12(6):296-311.
71. Rottem M, Shoenfeld Y. Vaccination and allergy. *Curr Opin Otolaryngol Head Neck Surg.* 2004;12(3):223-231.
72. Hoyt A, Schuyler A, Heymann P, Commins S, Platts-Mills T. Alum-containing vaccines increase total and food-allergen specific IgE, and cow's milk oral desensitization increases Bos d 4 IgG4 while peanut avoidance increases Ara h 2 IgE: the complexity of today's child with food allergy. *J Allergy Clin Immunol.* 2016;137(Suppl 2):AB151.
73. Nilsson L, Brockow K, Alm J, et al. Vaccination and allergy: EAACI position paper, practical aspects. *Pediatr Allergy Immunol.* 2017;28(7):628-640.
74. Calderon MA, Alves B, Jacobson M, Hurwitz B, Sheikh A, Durham S. Allergen injection immunotherapy for seasonal allergic rhinitis. *Cochrane Database Syst Rev.* 2007;1:CD001936.
75. Francis JN, Durham SR. Adjuvants for allergen immunotherapy: experimental results and clinical perspectives. *Curr Opin Allergy Clin Immunol.* 2004;4(6):543-548.
76. Bragazzi NL, Watad A, Amital H, Shoenfeld Y. Debate on vaccines and autoimmunity: do not attack the author, yet discuss it methodologically. *Vaccine* 2017;35(42):5522-5526.
77. Watad A, Quaresima M, Brown S, et al. Autoimmune/inflammatory syndrome induced by adjuvants (Shoenfeld's syndrome)—an update. *Lupus.* 2017;26(7):675-681.
78. (BfR) GfRA. No risk of Alzheimer's disease from aluminium in consumer products. Updated BfR Health Assessment. 2015;033/2007.
79. Wang Z, Wei X, Yang J, et al. Chronic exposure to aluminum and risk of Alzheimer's disease: a meta-analysis. *Neurosci Lett.* 2016;610:200-206.
80. Mirza A, King A, Troakes C, Exley C. The identification of aluminium in human brain tissue using lumogallion and fluorescence microscopy. *J Alzheimers Dis.* 2016;54(4):1333-1338.
81. Cluff CW. Monophosphoryl lipid A (MPL) as an adjuvant for anti-cancer vaccines: clinical results. *Adv Exp Med Biol.* 2010;667:111-123.
82. de la Torre MV, Baeza ML, Najera L, Zubeldia JM. Comparative study of adjuvants for allergen-specific immunotherapy in a murine model. *Immunotherapy.* 2018;10(14):1219-1228.
83. Fili L, Cardilicchia E, Maggi E, Parronchi P. Perspectives in vaccine adjuvants for allergen-specific immunotherapy. *Immunol Lett.* 2014;161(2):207-210.
84. Moradi Marjaneh R, Hassanian SM, Ghobadi N, et al. Targeting the death receptor signaling pathway as a potential therapeutic target in the treatment of colorectal cancer. *J Cell Physiol.* 2018;233(10):6538-6549.
85. Coccia M, Collignon C, Herve C, et al. Cellular and molecular synergy in AS01-adjuvanted vaccines results in an early IFN $\gamma$  response promoting vaccine immunogenicity. *NPJ Vaccines.* 2017;2:25.
86. Bell AJ, Heath MD, Hewings SJ, Skinner MA. The adsorption of allergoids and 3-O-desacyl-4'-monophosphoryl lipid A (MPL(R)) to microcrystalline tyrosine (MCT) in formulations for use in allergy immunotherapy. *J Inorg Biochem.* 2015;152:147-153.
87. Didierlaurent AM, Morel S, Lockman L, et al. AS04, an aluminum salt- and TLR4 agonist-based adjuvant system, induces a transient localized innate immune response leading to enhanced adaptive immunity. *J Immunol.* 2009;183(10):6186-6197.
88. Apostólico JDS, Boscardin SB, Yamamoto MM, et al. HIV envelope trimer specific immune response is influenced by different adjuvant formulations and heterologous prime-boost. *PLoS ONE* 2016;11(1):e0145637.
89. Rosewich M, Lee D, Zielen S. Pollinex Quattro: an innovative four injections immunotherapy in allergic rhinitis. *Hum Vaccin Immunother.* 2013;9(7):1523-1531.
90. Scichilone N, Sanfilippo A, Sorino C, Giuliano L, Misseri M, Bellia V. Allergen sensitizations in southern Italy: a 5-year retrospective study in allergic respiratory patients. *Eur Ann Allergy Clin Immunol.* 2013;45(3):97-102.
91. Patel P, Holdich T, Fischer von Weikersthal-Drachenberg KJ, Huber B. Efficacy of a short course of specific immunotherapy in patients with allergic rhinoconjunctivitis to ragweed pollen. *J Allergy Clin Immunol.* 2014;133(1):121-129.e2.
92. Rosewich M, Girod K, Zielen S, Schubert R, Schulze J. Induction of bronchial tolerance after 1 cycle of monophosphoryl-A-adjuvanted specific immunotherapy in children with grass pollen allergies. *Allergy Asthma Immunol Res.* 2016;8(3):257-263.
93. Worm M, Ernst D, Kraller M, Babina M. The impact on allergy-related cells of a birch pollen allergoid, with and without monophosphoryl lipid A, in comparison with the native equivalent. *Int Arch Allergy Immunol.* 2017;172(1):20-26.
94. Pfaar O, Lang S, Pieper-Fürst U, et al. Ultra-short-course booster is effective in recurrent grass pollen-induced allergic rhinoconjunctivitis. *Allergy* 2018;73(1):187-195.
95. Aryan Z, Holgate ST, Radzioch D, Rezaei N. A new era of targeting the ancient gatekeepers of the immune system: toll-like agonists in the treatment of allergic rhinitis and asthma. *Int Arch Allergy Immunol.* 2014;164(1):46-63.
96. Borgonovo L, Piconi S, Fusi A, Iemoli E. A case of anaphylaxis to Pollinex(R) Quattro MPL-4. *Eur Ann Allergy Clin Immunol.* 2014;46(1):46-48.
97. Apostolico Jde S, Lunardelli VA, Coirada FC, Boscardin SB, Rosa DS. Adjuvants: classification, modus operandi, and licensing. *J Immunol Res.* 2016;2016:1459394.

98. Zielen S, Gabrielpillai J, Herrmann E, Schulze J, Schubert R, Rosewich M. Long-term effect of monophosphoryl lipid A adjuvanted specific immunotherapy in patients with grass pollen allergy. *Immunotherapy*. 2018;10(7):529-536.
99. Pfaar O, Barth C, Jaschke C, Hormann K, Klimek L. Sublingual allergen-specific immunotherapy adjuvanted with monophosphoryl lipid A: a phase I/IIa study. *Int Arch Allergy Immunol*. 2011;154(4):336-344.
100. Cabral-Miranda G, Heath M, Mohsen M, et al. Virus-like particle (VLP) plus microcrystalline tyrosine (MCT) adjuvants enhance vaccine efficacy improving T and B cell immunogenicity and protection against *Plasmodium berghei/vivax*. *Vaccines (Basel)*. 2017;5(2).
101. Cabral-Miranda G, Heath MD, Gomes AC, et al. Microcrystalline tyrosine (MCT(R)): A depot adjuvant in licensed allergy immunotherapy offers new opportunities in malaria. *Vaccines (Basel)*. 2017;5(4).
102. Heath MD, Swan NJ, Marriott AC, et al. Comparison of a novel microcrystalline tyrosine adjuvant with aluminium hydroxide for enhancing vaccination against seasonal influenza. *BMC Infect Dis*. 2017;17(1):232.
103. Park KH, Lee SC, Son YW, et al. Different responses in induction of allergen specific immunoglobulin G4 and IgE-blocking factors for three mite subcutaneous immunotherapy products. *Yonsei Med J*. 2016;57(6):1427-1434.
104. Gupta RK, Siber GR. Adjuvants for human vaccines—current status, problems and future prospects. *Vaccine* 1995;13(14):1263-1276.
105. Masson JD, Thibaudon M, Belec L, Crepeaux G. Calcium phosphate: a substitute for aluminum adjuvants? *Expert Rev Vaccines*. 2017;16(3):289-299.
106. Lin Y, Wang X, Huang X, Zhang J, Xia N, Zhao Q. Calcium phosphate nanoparticles as a new generation vaccine adjuvant. *Expert Rev Vaccines*. 2017;16(9):895-906.
107. Leynadier F, Banoun L, Dollois B, et al. Immunotherapy with a calcium phosphate-adsorbed five-grass-pollen extract in seasonal rhinoconjunctivitis: a double-blind, placebo-controlled study. *Clin Exp Allergy*. 2001;31(7):988-996.
108. Briand A, Prélard P, Cochet-Faivre N, Drouet L. Safety evaluation of allergen specific immunotherapy without an induction phase using calcium phosphate adjuvanted allergenic extracts in atopic dogs: A retrospective study of one hundred eighty five cases. *Intern J Appl Res Vet Med*. 2018;16(2):203-210.
109. Jones S, Asokanathan C, Kmiec D, et al. Protein coated microcrystals formulated with model antigens and modified with calcium phosphate exhibit enhanced phagocytosis and immunogenicity. *Vaccine* 2014;32(33):4234-4242.
110. Kiel MA, Röder E, Gerth van Wijk R, Al MJ, Hop WCJ, Rutten-van Mölken MPMH. Real-life compliance and persistence among users of subcutaneous and sublingual allergen immunotherapy. *J Allergy Clin Immunol*. 2013;132(2):353-360.e2.
111. Lemberg ML, Berk T, Shah-Hosseini K, Kasche EM, Mosges R. Sublingual versus subcutaneous immunotherapy: patient adherence at a large German allergy center. *Patient Prefer Adherence*. 2017;11:63-70.
112. Sieber J, De Geest S, Shah-Hosseini K, Mosges R. Medication persistence with long-term, specific grass pollen immunotherapy measured by prescription renewal rates. *Curr Med Res Opin*. 2011;27(4):855-861.
113. Roberts G, Pfaar O, Akdis CA, et al. EAACI guidelines on allergen immunotherapy: allergic rhinoconjunctivitis. *Allergy* 2018;73(4):765-798.
114. Lee J-H, Lee S-H, Ban G-Y, et al. Factors associated with adherence to allergen specific subcutaneous immunotherapy. *Yonsei Med J*. 2019;60(6):570-577.
115. Janson C, Sundbom F, Arvidsson P, Kampe M. Sublingual grass allergen specific immunotherapy: a retrospective study of clinical outcome and discontinuation. *Clin Mol Allergy*. 2018;16:14.

## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

**How to cite this article:** Jensen-Jarolim E, Bachmann MF, Bonini S, et al. State-of-the-art in marketed adjuvants and formulations in Allergen Immunotherapy: A position paper of the European Academy of Allergy and Clinical Immunology (EAACI). *Allergy*. 2019;75:746–760. <https://doi.org/10.1111/all.14134>