As stressed by Gagneur and Pinquier, some studies [3] have demonstrated the existence of both a humoral and cellular immune response to measles vaccine when administrated early in life, even in the presence of maternal antibodies. “However, since a modification of the summary of product characteristics (SPC) of the M-M-R-VAXPRO vaccine was needed to allow its administration at nine months of age, the immune response according to the age of administration has been studied [4]: after the second dose (administered three months after the first), children who had received the first dose at nine months of age had a seroprotection rate against measles of 94.6%, (95% confidence interval (CI): 92.3–96.4) compared to 98.9% (95% CI: 97.5–99.6) for those vaccinated at 12 months of age. Similarly, geometric mean antibodies titles for measles was significantly lower in children immunised at age nine months. So, the SPC mentions that administration of this vaccine at nine months of age should be reserved to certain circumstances (for example for children admitted to daycare centres, for epidemics and for travel in countries with high incidence of measles) and that an additional dose (i.e. a third dose) of vaccine should be provided to children who received the first dose at nine months of age [4].

In our study 135 (56%) of the notified cases in children aged under one year were under nine months-old. Thus, starting the immunisation at nine months of age would have left the majority of them unprotected.

Finally, we know that the current prolonged outbreak of measles in our country is due to the existence of a large cohort of susceptible children, adolescents and young adults who had neither the vaccination nor the disease. In our opinion, reducing the size of this cohort by catch-up vaccination campaigns in the unvaccinated population (according to the official recommendations) is the best way to interrupt the circulation of measles virus and to protect the infants through herd immunity.
References


