Down-Regulation of IgE and IgG4 Antibodies to Tetanus Toxoid and Diphtheria Toxoid by Covaccination with Cellular Bordetella pertussis Vaccine

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A rise in the prevalence of allergic diseases has been observed in recent decades in industrialized countries (1). Marked prevalence differences within populations of a close genetic background but profound lifestyle differences suggest that environmental variations are responsible (2, 3). In this context, early childhood vaccinations as planned immunological interventions have attracted interest because they may alter the cytokine milieu and thus render the children more or less susceptible to IgE formation and subsequent IgE-mediated allergy against otherwise harmless environmental Ags (4).

We have shown previously that in German children of a prospectively followed birth cohort (MAS-90), considerable IgE responses are constituents of the regular immune response toward diphtheria (D) and tetanus (T) immunization, however exaggerated in atopic (5, 6). Pertussis (P) toxin and the chemically derived toxoid have a long tradition as an adjuvant for IgE formation against simultaneously administered Ags in animal models (7, 8). Thus, vaccination against P may also have an adjuvant impact on IgE formation against coadministered D and T Ags in humans. Sera of 103 D-T-P-immunized and 319 D-T-immunized children aged 2 years were analyzed for IgE, IgG4, and IgG to D and T (radioallergosorbent test), total IgE and IgE against common inhalant allergens (CAP radioallergosorbent test fluoroenzyme immunoassay). Fewer D-T-P- than D-T-immunized children had sera positive for T-IgE (12.6 vs 53.6%, \( p < 0.001 \)), D-IgE (31.0 vs 70.5%, \( p < 0.001 \)), and D-IgG4 (85.2 vs 93.4%, \( p = 0.039 \)). Suppression of T-IgE was not dependent on the cutoff chosen for a positive test result, but was dependent on the proportion of D-T immunizations given with P. The risk for sensitization to common environmental allergens did not differ (odds ratio 0.953, 95% confidence interval 0.815–1.114). No significant differences between D-T- and D-T-P-immunized children were found with regard to T-IgG or D-IgG. In summary, IgE and IgG4 (but not IgG) serum levels to coadministered D- and T-Ags are suppressed among P-immunized children as compared with nonimmunized children. These results suggest that the presence of a microbial product during Ag exposure can down-regulate an IgE/IgG4 response in humans. The Journal of Immunology, 2001, 167: 2411–2417.

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**Patients and Methods**

**Study population**

In 1990, a cohort of 1314 neonates recruited in five German cities (Berlin, Düsseldorf, Freiburg, Mainz, and Munich) was selected for a prospective observational study (MAS-90). Of these, 499 neonates (38%) were selected as being at high risk for atopy (two or more close atopic family members and/or cord blood IgE values above 0.9 kU/L), and the remainder were at random risk.

The cohort infants and their parents were regularly seen for follow-up visits at ages 3, 6, 12, 18, 24, and 36 mo. Parents filled in a questionnaire and gave a structured interview about their children’s diseases and atopic symptoms. To keep the reporting bias low, parents kept a diary, recording details of all their children’s illnesses. The study coordinators monitored the diary during the regular standardized physical examination by trained study physicians (10).

For this study, cohort children were included in the study if they had received immunizations against D and T before their second birthday, if the records of immunization including the date of each

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**Abbreviations used in this paper:**
- D: diphtheria
- T: tetanus
- P: pertussis
- BCG: bacillus Calmette-Guérin
- RAST: radioallergosorbent test
- RU: RAST units
- LF: limit of flocculation units

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3. Abbreviations used in this paper: D, diphtheria; T, tetanus; P, pertussis; BCG, bacillus Calmette-Guérin; RAST, radioallergosorbent test; RU, RAST units; LF, limit of flocculation units.

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injection were complete, there was no suspected P infection, and the serum volume was sufficient. Because IgG4 analysis was performed at a 1/40 dilution, more material was available for this assay than for the IgE analysis working with undiluted serum. If serum availability was limiting, T assay was given priority. T-IgE was available from all children. T-IgG4 was available from 316/319 DT-vaccinated and from 102/103 DTP-vaccinated children. D-IgE and D-IgG4 were available from 200 and 256 DT-vaccinated and from 58 and 81 DTP-vaccinated children, respectively. For the analyses with respect to BCG vaccination, children with a history of tuberculosis or BCG vaccination after the first DT vaccination were additionally excluded.

Vaccinations

In Germany, P vaccination was not officially recommended before 1991. DT vaccination shots were recommended at 3 and 4 mo of age. A booster shot was recommended 1 year later. For DTP vaccination, immunizations were recommended at ages 3, 4, 5, and 15 mo. However, vaccination history of the children was variable. Corresponding to the cohort character, there was no intervention regarding timing of vaccination and selection of vaccine preparations. Vaccinations were recorded from official vaccination documents that were available for all children of the cohort. An infant with documented vaccination was regarded as vaccinated; all other infants were regarded as nonvaccinated.

D-T vaccinations were performed with vaccines containing D toxoid 30–50 IU, T toxoid 40–50 IU, and aluminum as an adjuvant (aluminum hydroxide or aluminum phosphate, 1.25–1.50 mg). D-T-P vaccinations were performed with a whole cell P vaccine containing D toxoid 50 IU, T toxoid 50 IU, aluminum hydroxide 0.75 mg, aluminum phosphate 0.75 mg, and heat-inactivated B. pertussis 4 IU. Vaccination cases included in this study had two or more shots in the first year of life and no P infection.

In Germany, infants believed to be at increased risk of tuberculosis infection used to be vaccinated shortly after birth. Infants were vaccinated with an attenuated BCG strain (10^5 bacteria, Copenhagen strain 1331; BCG-Vaccine Behring, Marburg, Germany).

Definition of atopic diseases and allergic sensitization

A basic description of morphological skin phenomena and their localization was used to construct a computer algorithm for the definition of atopic eczema according to the morphological criteria followed by Seymour et al. (11). A similar but simpler question sheet was filled out by the mothers regarding the case history of the preceding period (12). Obvious recurrent wheezing bronchitis required at least two wheezing episodes with shortness of breath. Obvious atopic rhinitis was diagnosed in the case of blocked and/or running nose without a cold lasting for two or more months during the preceding observation period, with the diagnosis by a physician (12). A child was considered sensitized if the IgE Ab titer of one or more of the nine allergens tested was ≥0.35 kU/L.

Determination of allergen concentration in house dust

The levels of major mite (Der p 1 and Der f 1) and cat (Fel d 1) allergens were determined from domestic carpet dust samples by sandwich ELISA as described previously (13).

Determination of IgE

Venous blood samples were obtained at birth (cord blood), 12, 24, and 36 mo, and serum was separated by centrifugation at 3500 rpm for 13 min. Serum samples were stored at −20°C until analysis.
α level of 0.05. Bonferroni adjustments were used for multiple comparisons.

Results

Study population

We included 422 of the cohort children in our study of which 319 children had received no P vaccination and 103 children whole cell P vaccination. Some of the P-vaccinated group (24 children) had not received P vaccine with all DT shots.

P-vaccinated and nonvaccinated children did not significantly differ with regard to gender, hereditary risk for atopy, cord blood IgE levels, siblings, indoor cat allergen exposure, common childhood infections, or further vaccinations. However, the mite allergen exposure was lower among the P-vaccinated children (Table I).

Children received a median of four shots DT vaccine (range 1–6 shots). The median of DT shots was lower in the DT group than in the DTP-vaccinated group (median, three vs four shots, p < 0.001; Table II). One child had a diagnosis of tuberculosis, and four children were excluded from the calculations in view of a possible infection, or further vaccinations. However, the mite allergen exposure was lower among the P-vaccinated children (Table I).

Table I. Patient characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>DT-Vaccinated (n = 319)</th>
<th>DTP-Vaccinated (n = 103)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>51.7</td>
<td>58.3</td>
<td>0.248</td>
</tr>
<tr>
<td>Cord blood IgE &gt; 0.9 kU/L (%)</td>
<td>17.8</td>
<td>15.3</td>
<td>0.664</td>
</tr>
<tr>
<td>Parents sensitized (%)</td>
<td>37.9</td>
<td>32.9</td>
<td>0.420</td>
</tr>
<tr>
<td>Family history (%)</td>
<td>48.0</td>
<td>43.8</td>
<td>0.613</td>
</tr>
<tr>
<td>Sibling at birth (%)</td>
<td>69</td>
<td>71</td>
<td>0.246</td>
</tr>
<tr>
<td>Median cat allergen exposure (Fel d1 /g carpet dust, mean 6th/18th month)</td>
<td>253</td>
<td>150</td>
<td>0.024</td>
</tr>
<tr>
<td>Siblings at birth (%)</td>
<td>54.0</td>
<td>48.4</td>
<td></td>
</tr>
<tr>
<td>Infections in the first 2 years of life (%)</td>
<td>1.6</td>
<td>1.0</td>
<td>1.000</td>
</tr>
<tr>
<td>Further vaccinations in the first 2 years of life (%)</td>
<td>2.3</td>
<td>0.7</td>
<td>1.000</td>
</tr>
<tr>
<td>Measles</td>
<td>66.1</td>
<td>74.8</td>
<td>0.103</td>
</tr>
<tr>
<td>Mumps</td>
<td>66.5</td>
<td>75.7</td>
<td>0.078</td>
</tr>
<tr>
<td>Rubella</td>
<td>65.8</td>
<td>75.7</td>
<td>0.061</td>
</tr>
<tr>
<td>H. influenzae type B</td>
<td>85.6</td>
<td>82.5</td>
<td>0.452</td>
</tr>
<tr>
<td>BCG</td>
<td>7.8</td>
<td>6.8</td>
<td>0.894</td>
</tr>
</tbody>
</table>

No. of vaccination shots against T/D among P-vaccinated and nonvaccinated children

<table>
<thead>
<tr>
<th>No. Shots</th>
<th>DT (%)</th>
<th>DTP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.3</td>
<td>3.9</td>
</tr>
<tr>
<td>3</td>
<td>81.5</td>
<td>30.1</td>
</tr>
<tr>
<td>4</td>
<td>0.6</td>
<td>63.1</td>
</tr>
<tr>
<td>5–6</td>
<td></td>
<td>2.9</td>
</tr>
</tbody>
</table>

from 316/319 DT-vaccinated and from 102/103 DTP-vaccinated children. D-IgE and D-IgG4 were available from 200 and 256 DT-vaccinated and from 58 and 81 DTP-vaccinated children, respectively.

P vaccination and IgE response

As compared with the DT-vaccinated group, the mean anti-T serum IgE level was significantly lower in the DTP-vaccinated group (Fig. 1). Accordingly, the proportion of sera with anti-T IgE >0.3 RU/ml was lower in the DTP-vaccinated group (12.6 vs 53.6%, p < 0.001). This was not dependent on the cutoff chosen for a RAST-positive result (Fig. 2). Measles-mumps-rubella vaccination was somewhat more prevalent in the DTP-vaccinated group (Table I); however, the group of measles-mumps-rubella-vaccinated children had a similar median anti-T IgE level to that for nonvaccinated children (0.05 vs 0.13 RU/ml; p = 0.878).

The correlation between the number of DT shots and anti-T IgE was rather poor (r = –0.025, p = 0.614). Although the number of children incompletely covaccinated with P is not large, the number of DT shots received without P seems to increase the proportion of RAST-positive anti-T IgE levels in a dose-dependent fashion (Fig. 3). This analysis was restricted to children with 3–4 shots, because the numbers of children with 1–2 shots or with 5–6 shots were too small to allow a good comparison between DT and DTP (see Table II).

The time intervals between the last D and T immunization and the blood draw for the D- and T-specific Ab analysis ranged from 1 wk to 20 mo. Among DT-vaccinated children, anti-T IgE serum levels are highest during the first month after immunization and decrease over time to the low level that is found in the sera of DPT-vaccinated children during all time intervals throughout (Fig. 4).
Serum levels of IgE to D are highly correlated with those to T-IgE (Fig. 5). Weaker correlation exists between total serum IgE at 2 years and T-IgE (\( r_s = 0.648; p = 0.001 \)) or D-IgE (\( r_s = 0.654; p = 0.001 \)) as well as cord blood IgE and T-IgE (\( r_s = 0.212; p = 0.009 \)). Like the IgE response to T toxoid, the levels are markedly suppressed in DTP-vaccinated children (Fig. 6).

During the first 2 years of life, total IgE levels are transiently significantly lower in sera of DTP-vaccinated than in sera of DT-vaccinated children. The proportion of children sensitized to common airborne and nutritive allergens is nonsignificantly lower among DTP-vaccinated children at all examination dates (Table III).

P vaccination and IgG4 and IgG response

The rates of seropositivity to IgG4 are higher in both groups than the rates for IgE. As with IgE, the rates of IgG4 to both Ags, D and T toxoid, are statistically significantly suppressed in DPT-vaccinated individuals. However, this effect is less impressive than for IgE (Fig. 7).

The median serum levels of T-IgG4 (P25, P75) are 13.6 RU/ml (2.7 RU/ml, 61.1 RU/ml) among DT-vaccinated children and 2.3 RU/ml (0.0 RU/ml, 6.3 RU/ml) among DTP-vaccinated children (\( p > 0.001 \)). The corresponding levels of IgG4 to D are 22.2 RU/ml (4.0 RU/ml, 82.9 RU/ml) and 5.2 RU/ml (2.1 RU/ml, 17.9 RU/ml; \( p < 0.001 \)) among DT- and DTP-vaccinated children, respectively.

Unlike IgE and IgG4, IgG levels seem not to be influenced by vaccination with P. IgG levels are available from 21 DT-vaccinated and from 14 DTP-vaccinated children. Serum levels of T-IgG (median; P25, P75) do not differ between DT-vaccinated (1.4 RU/ml; 0.3 RU/ml, 2.8 RU/ml) and DTP-vaccinated children (1.1 RU/ml; 0.5 RU/ml, 4.7 RU/ml). The proportion of sera with T-IgG above cutoff is similar in both groups (16/21 DT-vaccinated children and 12/14 DTP-vaccinated children).

BCG vaccination and Ig response

In contrast to P vaccination, serum levels of T-IgE (median; P25, P75) do not statistically significantly differ between BCG-vaccinated and from nonvaccinated children. Serum levels of T-IgG (median; P25, P75) do not differ between BCG-vaccinated (1.4 RU/ml; 0.3 RU/ml, 2.8 RU/ml) and nonvaccinated children (1.1 RU/ml; 0.5 RU/ml, 4.7 RU/ml). The proportion of sera with T-IgG above cutoff is similar in both groups (16/21 DT-vaccinated children and 12/14 DTP-vaccinated children).
levels are similar between BCG-vaccinated (13.5 RU/ml; 2.1 RU/ml; 53.2 RU/ml) and nonvaccinated children (8.2 RU/ml; 1.5 RU/ml; 43.6 RU/ml; \( p = 0.393 \)).

However, serum levels of D-IgE (median; P25, P75) are lower in nonvaccinated children (0.2 RU/ml; 0.0 RU/ml; 1.9 RU/ml) than in BCG-vaccinated children (1.6 RU/ml; 0.0 RU/ml; 4.5 RU/ml; \( p = 0.024 \)). D-IgG4 levels are analogous to D-IgE levels and are lower in nonvaccinated children (11.9 RU/ml; 2.7 RU/ml; 50.6 RU/ml) than in BCG-vaccinated children (67.4 RU/ml; 9.5 RU/ml; 170.2 RU/ml; \( p < 0.001 \)).

The baseline characteristics listed in Table I did not differ statistically between BCG-vaccinated and nonvaccinated children. The proportion of P-vaccinated children was equal in both groups. Frequency of respiratory infections during the first three years could not explain this difference (data not shown).

**Discussion**

Our results demonstrate a striking suppressive effect of whole cell P vaccine on IgE formation to coadministered T and D Ags in early childhood. This finding conflicts with results from animal studies that indicate an IgE-promoting effect of P toxin with regard to coadministered unrelated Ags (8, 16–18). In fact, in humans, not only IgE production (19, 20), but also the promotion of clinical correlates of atopy, has been a concern with P infection (21–23) or P vaccination (24, 25), although a causal relationship has never been established and other studies have failed to show an allergy-promoting effect (26–28).

Transient formation of IgE to the vaccinated Ags is commonly detected and seems to be part of the regular immune response (5, 6, 29–32). The biological function of this has not been elucidated fully but it may be the expression of a Th2-balanced Th1 response that optimizes host defense. Recent data on P have indicated a different response pattern of whole cell and acellular P vaccine. PBMC of whole cell P-immunized children respond with high IFN-γ and low IL-5 secretion, a pattern that has also been found in PBMC of P-infected children (33–35). In contrast, PBMC from children immunized with acellular vaccines show a higher production of IL-4 and IL-5 (34–36). This finding is mirrored in higher levels of IgE to P toxin itself in children immunized with whole cell as compared with those immunized with acellular vaccines (32).

This effect is possibly related to cell wall components such as LPS. A murine study that investigated the influence of LPS exposure on IgE indicated that LPS stimulates B cells to differentiate into IgG-producing plasma cells if LPS is given before the Ig isotype switch has occurred. If given after the switch, LPS directly stimulates those B cells that have been primed to produce IgE (37). Our study indicates that whole cell P vaccine has the potential to suppress the Th2-associated branch of the humoral immune response to Ags if these are administered simultaneously. However, sensitization to common environmental allergens not given with the vaccine seems to be unaffected in our study and in other studies (32, 38).

Like IgE, secretion of IgG4 is IL-4-dependent (39). In this study, suppression of IgG4 serum levels in P-vaccinated children parallels suppression of IgE. In contrast, total IgG serum levels do not differ between DT- and DTP-vaccinated children.

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**Table III.** Odds ratios (OR) and 95% confidence interval for specific sensitization to common allergens and joint prevalences of atopic dermatitis and recurrent wheeze at 12, 24, and 36 mo of life in DT-vaccinated children with P covaccination (DTP; \( n = 319 \)) in comparison with children not covaccinated (OR = 1.0; \( n = 103 \))

<table>
<thead>
<tr>
<th>Age, Condition</th>
<th>OR</th>
<th>95% Confidence Interval</th>
<th>( p ) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 mo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elevated total IgE</td>
<td>0.424</td>
<td>0.230–0.783</td>
<td>0.008</td>
</tr>
<tr>
<td>Sensitization</td>
<td>0.945</td>
<td>0.810–1.124</td>
<td>0.717</td>
</tr>
<tr>
<td>Atopic dermatitis</td>
<td>0.973</td>
<td>0.798–1.187</td>
<td>0.966</td>
</tr>
<tr>
<td>Recurrent wheeze</td>
<td>0.891</td>
<td>0.728–1.092</td>
<td>0.584</td>
</tr>
<tr>
<td>24 mo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elevated total IgE</td>
<td>0.418</td>
<td>0.236–0.741</td>
<td>0.004</td>
</tr>
<tr>
<td>Sensitization</td>
<td>0.953</td>
<td>0.815–1.114</td>
<td>0.689</td>
</tr>
<tr>
<td>Atopic dermatitis</td>
<td>0.875</td>
<td>0.755–1.014</td>
<td>0.225</td>
</tr>
<tr>
<td>Recurrent wheeze</td>
<td>0.956</td>
<td>0.773–1.183</td>
<td>0.889</td>
</tr>
<tr>
<td>36 mo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elevated total IgE</td>
<td>0.688</td>
<td>0.364–1.298</td>
<td>0.314</td>
</tr>
<tr>
<td>Sensitization</td>
<td>0.919</td>
<td>0.811–1.040</td>
<td>0.283</td>
</tr>
<tr>
<td>Atopic dermatitis</td>
<td>0.850</td>
<td>0.758–0.954</td>
<td>0.037</td>
</tr>
<tr>
<td>Recurrent wheeze</td>
<td>0.880</td>
<td>0.753–1.028</td>
<td>0.274</td>
</tr>
</tbody>
</table>

* Specific IgE ≤ 0.35 kU/L against egg, milk, soy, wheat, birch, timothy, mite, cat (12, 24, 36 mo), or dog (36 mo).
findings support the view that P suppresses the Th2-associated branch of the immune response.

Unlike P, antecedent BCG did not suppress IgE or IgG4 levels. In murine studies, BCG acted as a strong Th1 promoter and suppressed IgE formation to unrelated Ags (40, 41). However, in children, a convincing effect of early BCG vaccination on later development of IgE to common environmental allergens has not been found (42, 43). This may be a dose problem because studies investigating tuberculosis-infected patients suggest a possible effect (44, 45). One study investigating BCG-vaccinated Japanese children reporting an inverse correlation of IgE and skin test reactivity to mycobacterial Ag presumably involved children that were infected with environmental mycobacteria (9). This inverse correlation has not been reproduced in our prospective cohort, or in a study of Norwegian adults (43, 46).

P-vaccinated and nonvaccinated subpopulations were carefully studied for possible confounding and were found to be comparable with regard to common known confounders such as heredity for atopy, allergen exposure, infections, and further vaccinations. There has been a controversial discussion of the extent to which the production of IgE against vaccinated Ags is due to the toxoids themselves or is an effect of alum as adjuvant. However, IgE against T and D toxoids is also detectable after booster doses of nonadsorbed vaccines (47, 48). We could not adjust for different brands of DT vaccine, but there was little variation in the composition of the products available at that time.

In murine studies the vaccination schedule in 1990 recommended two shots and one booster shot for DT vaccination. For DTP vaccination, three shots and one booster shot for DT vaccination. For DTP vaccination, three shots and one booster shot were recommended. In our cohort, 80% of the DT-vaccinated children received three shots and 70% of the DTP children received four shots. However, the correlation of vaccination doses and T-IgE was rather low. In contrast, we found a dose-response-like relationship between the proportion of DT shots with P and T-IgE serum level. This suggests that P vaccine is required at the time when D and T Ags are administered to suppress IgE formation against these Ags.

In summary, we found a strong suppressive effect of P vaccine on IgE and IgG4 formation against coadministered D and T Ags. This effect seems to be dose-dependent. In contrast, BCG vaccination given before DT immunization has no suppressive effect. It may be speculated that administration of common environmental allergens together with a Th1-deviating vaccine results in the prevention or even reversion of IgE formation against these allergens. Although this approach is currently not available as an Ag-specific therapeutic option for children, it is important to note that routine DT vaccination with P does not seem to increase the risk of IgE formation or related disease. Access to these life-saving vaccines should be regarded as a basic human right of every child—atopic or not.

References


