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COMMENT LETTERS

Guillain-Barré Syndrome Associated with COVID-19 Vaccination

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To the Editor: With interest we read the article by Shao et al. (*1*) about the frequency of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) vaccination–associated Guillain-Barré syndrome (SCoVaG) among 18,269 healthcare workers in Taiwan who had received the AstraZeneca vaccine (AZV; https://www.astrazeneca.com). Only 1 vaccinee experienced SCoVaG during the study period (*1*). The study is appealing but raises concerns.

Recently, our review of 19 SCoVaG patients, for whom data were collected through June 2021, was published (*2*). The 9 men and 10 women in the study were 20–86 years of age. All patients experienced SCoVaG after the first vaccine dose. AZV was given to 14 patients, the Pfizer-BioNTech (https://www.pfizer.com) vaccine to 4 patients, and the Johnson & Johnson (https://www.jnj.com) vaccine to 1 patient. Latency between vaccination and SCoVaG onset ranged from 3 hours to 39 days. Patients received intravenous immune globulin (n = 13), steroids (n = 3), or no therapy (n = 3). Six patients required mechanical ventilation. One patient recovered completely; 9 achieved partial recovery (*2*). Only 1 of the studies included in our review mentioned the total number of vaccinated persons (*3*); in that study, 7 persons among 1.2 million vaccinated persons were found to have SCoVaG (*3*).

In addition, data on 389 patients with SCoVaG were collected in a recent review about the neurologic adverse events of SARS-CoV-2 vaccination (*4*). However, no individual data were provided for 337

of these patients (*4*). Among the 53 patients for whom individual data were available, AZV was given to 39 patients, Pfizer-BioNTech vaccine to 9 patients, and Johnson & Johnson vaccine to 2 patients.

For the Shao et al. report (*1*), we wondered why the oldest healthcare worker was 86 years of age. Also missing were the specific treatment and outcome of the patient with SCoVaG.

Available data suggest that SCoVaG is a rare complication of SARS-CoV-2 vaccination, irrespective of the vaccine brand used. SCoVaG should be diagnosed early so treatment can be initiated promptly. Whether the beneficial effect of SARS-CoV-2 vaccination outweighs the risk for adverse events (e.g., Guillain-Barré syndrome) remains a matter of discussion (*5*).

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SARS-CoV-2 Cross-Reactivity in Prepandemic Serum from Rural Malaria-Infected Persons, Cambodia

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To the Editor: We read with interest the observations by Manning et al. (*1*) that serum collected from malaria-infected persons in Cambodia before the coronavirus disease (COVID-19) pandemic harbored seroreactivity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) antigens but lacked neutralizing activity. These results suggest that malaria exposure may increase background reactivity in SARS-CoV-2 serosurveys and more specific measures of exposure, such as surrogate virus neutralization tests (sVNTs), may be necessary to capture functional SARS-CoV-2 seroreactivity in malaria-endemic areas. Additional studies in settings with distinct malaria transmission intensities would generalize and strengthen these findings.

One hypothesis for the unexpectedly moderate burden of SARS-CoV-2 in malaria-endemic countries in Africa is that exposure to *Plasmodium falciparum* confers functional protection against COVID-19 through cross-reactivity or general immune activation. To test this hypothesis, we analyzed 237 dried blood spot samples taken in January 2020 (prepandemic) from *P. falciparum*–exposed persons in a high-transmission setting in western Kenya for the presence of SARS-CoV-2 neutralizing antibodies (nAbs) using the GenScript SARS-CoV2 sVNT assay (https://www.genscript.com). Monthly *P. falciparum* real-time PCR results were collected in a previous study (*2*) for 138/237 persons in the 12 months prior to January 2020. Of these, 131 (95%) were infected with *P. falciparum* at least 1 time in 2019, suggesting that most persons included in this screening had been recently exposed to malaria parasites.

Consistent with findings in Manning et al. (*1*), none of the 237 people harbored SARS-CoV-2 nAbs, despite high prior levels of exposure to *P. falciparum*. Although nAbs are subject to decay after infection (*3*), this lack of nAb activity suggests that sVNTs offer a more specific measure of SARS-CoV-2 exposure than standard ELISAs (*4*). We further suggest that, given that protection from SARS-CoV-2 infection may be associated with the presence of nAbs (*5*), their absence in samples from both the Manning et al. study