

Drs. Ramdani and Audemard-Verger reply

To the Editor:

First, we would like to thank Wang and colleagues for their careful reading and relevant comments.¹

Concerning the first remark, it is indeed an error on the pre-proof manuscript, which has been corrected in the final version.

Regarding the incidence of IgA vasculitis (IgAV), it is true, as Wang et al point out, that it varies according to country and season. However, most of the data concern children,^{2,3} which is the main population affected by this disease, but our study was limited to adult IgAV.

In the adult IgAV population, data are scarce; in particular, there are no precise French data, annual or otherwise.^{4,5} Due to this lack of global data, and the unstandardized form of our cases, our study cannot address with precision the relevant points made by Wang et al.¹

Regarding seasonality, 66% of our patients had their first symptoms after a vaccination occurring over a period from May to August, which is obviously not the classical period of both respiratory and digestive infections. We also want to highlight that in almost all the patients described in the case series, IgAV was not induced by bacterial or viral infection. It is true that it is difficult to have a precise view of IgAV incidence before and after COVID-19 due to a lack of robust and global data. Obviously, we also think that the COVID-19 pandemic could have decreased IgAV incidence.

Strikingly, we had the opportunity to conduct a pharmacovigilance study using the World Health Organization Vigibase.⁶ We showed a significant increase in IgAV reporting with

COVID-19 vaccines compared with all other drugs (information component [IC] 0.22, credible interval [CrI] 0.04 to 0.35). No disproportionality signal was found between COVID-19 and other vaccines (IC –1.42, CrI –1.60 to –1.28).⁶

Altogether, this case series and the pharmacovigilance study argue for a truth rather than an illusion.

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The authors declare no conflicts of interest relevant to this article.

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