The Journal of Rheumatology 2023;xx:xxxxxx
doi:10.3899/jrheum.221295
First Release March 15 2023

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.

Yanis Ramdani[1], MD
Alexandra Audemard-Verger[1], MD, PhD
[1]Department of Internal Medicine and Clinical Immunology, CHRU de Tours, and Université de Tours, Tours, France.

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

Address correspondence to Dr. A. Audemard-Verger, Department of Internal Medicine and Clinical Immunology, CHRU de Tours, and Université de Tours, Tours, France.
Email: alexandra.audemardverger@univ-tours.fr.

REFERENCES

1. Wang G, Luo Y, Li B, Li J. COVID-19 vaccination as a trigger of IgA Vasculitis: truth or illusion? J Rheumatol xxxxxxx.
2. Piram M, Maldini C, Biscardi S, et al. Incidence of IgA vasculitis in children estimated by four-source capture-recapture analysis: a population-based study. Rheumatology 2017;56:1358-66.
3. Mossberg M, Segelmark M, Kahn R, Englund M, Mohammad AJ. Epidemiology of primary systemic vasculitis in children: a population-based study from southern Sweden. Scand J Rheumatol 2018;47:295-302.
4. Piram M, Mahr A. Epidemiology of immunoglobulin A vasculitis (Henoch-Schönlein): current state of knowledge. Curr Opin Rheumatol 2013;25:171-8.
5. Hočevar A, Rotar Z, Jurčić V, et al. IgA vasculitis in adults: the performance of the EULAR/PRINTO/PRES classification criteria in adults. Arthritis Res Ther 2016;18:58.
6. Ramdani Y, Largeau B, Jonville-Bera AP, et al. COVID-19 vaccination as a trigger of IgA vasculitis: a global pharmacovigilance study. J Rheumatol 2022 Nov 15 (Epub ahead of print).