Response to comment on "An evidence-based guide to SARS-Cov-2 vaccination of patients on immunotherapies in dermatology."

To the Editor: We would like to thank Speeckaert et al for their thoughtful comments on our article. We appreciate the authors' attention to detail in noting that in the study by Cho et al,[1] although rituximab exposure did not significantly affect the humoral response to seasonal influenza vaccination in patients with autoimmune blistering disease, the interpretation was limited as rituximab treatment had been discontinued for at least 5 months prior to the vaccination.[1] Based on the study of ocrelizumab (a humanized anti-CD20 antibody),[2] Waldman et al[3] have suggested the timing of the vaccination to be at least 4 weeks prior to anti-CD20 administration, and/or vaccinating the patients 12-20 weeks after a treatment cycle. Until further data are available, we endorse this position.

In our review, we discussed the temporary withholding of immunosuppressive medication prior to vaccination or following it to improve antibody responses and referred to current published guidelines. The safety and efficacy of this maneuver has only been demonstrated for methotrexate in the setting of influenza vaccination in rheumatoid arthritis. Although an extrapolation to the patients with skin disease and COVID-19 vaccination is reasonable, the specific data are missing. Patients with skin conditions treated with Janus kinase inhibitors may flare more rapidly upon drug cessation than those treated with methotrexate as has been demonstrated in preclinical models[4]; thus, we agree with the authors that withholding Janus kinase inhibitors cannot be routinely recommended at this time. The final decision to withhold immunotherapy to maximize vaccine efficacy will always be a risk/benefit discussion between the patient and the physician.

Vaccine induced antibody response after the first dose of a SARS-CoV-2 messenger RNA vaccine was recently shown to be significantly reduced in solid organ transplant patients receiving maintenance immunosuppressive therapy.[5] Patients who were not receiving antimetabolite maintenance immunosuppression were more likely to mount a satisfactory immune response.[5] These findings are in line with our conclusion that dermatology patients treated with antimetabolite immunosuppressive therapies may demonstrate variable antibody levels against SARS-CoV-2. This study also supports the possibility that dermatology patients treated with mycophenolate may show decreased post-vaccination antibody titres. We look forward to reviewing further data regarding the real-world SARS-CoV-2 vaccine efficacy in dermatologic patient populations as they become available, following the more widespread SARS-CoV-2 vaccine distribution.

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Conflicts of interest
None disclosed.

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