

ORIGINAL ARTICLE

Hereditary thrombotic thrombocytopenic purpura and COVID-19: Impacts of vaccination and infection in this rare disease

Erika Tarasco PhD^{1,2}  | Anne Sophie von Krogh MD^{3,4} | Radomira Hrdlickova MD⁵ | Thomas R. Braschler MD⁶ | Teresa Iwaniec PhD⁷ | Paul N. Knöbl MD⁸  | Eriko Hamada MD⁹  | Oleg Pikovsky MD¹⁰ | Stefan Farese MD¹¹ | Odit Gutwein MD¹² | Petr Kessler MD¹³ | Nina H. Schultz MD¹⁴ | Charis von Auer MD¹⁵ | Jerzy Windyga MD¹⁶ | Kenneth Friedman MD¹⁷ | Ingrid Hrachovinova PhD¹⁸  | James N. George MD¹⁹ | Masanori Matsumoto MD⁹  | Reinhard Schneppenheim MD²⁰ | Bernhard Lämmle MD^{1,21}  | Johanna Anna Kremer Hovinga MD^{1,2} 

¹Department of Hematology and Central Hematology Laboratory, Inselspital, Bern University Hospital, Bern, Switzerland

²Department for BioMedical Research (DBMR), University of Bern, Bern, Switzerland

³Department of Hematology, St. Olavs Hospital, Trondheim University Hospital, Trondheim, Norway

⁴Department of Clinical and Molecular Medicine, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, Trondheim, Norway

⁵Blood Center, University Hospital Ostrava, Ostrava, Czech Republic

⁶Center for Clinical Hematology, Luzerne Kantonsspital, Lucerne, Switzerland

⁷Department of Hematology, Jagiellonian University Medical College, Krakow, Poland

⁸Division of Hematology and Hemostasis, Department of Medicine I, Medical University of Vienna, Vienna, Austria

⁹Department of Blood Transfusion Medicine, Nara Medical University, Kashihara, Japan

¹⁰Transfusion Medicine Institute, Faculty of Health Sciences, Ben-Gurion University of the Negev, Soroka University Medical Center, Beer-Sheva, Israel

¹¹Department of Nephrology, Burgerspital, Solothurn, Switzerland

¹²Department of Hematology, Shamir Medical Center, Zerifin, Israel

¹³Department of Hematology and Transfusion Medicine, Hospital Pelhrimov, Pelhrimov, Czech Republic

¹⁴Department of Hematology, Oslo University Hospital, Oslo, Norway

¹⁵Department of Hematology, Oncology, and Pneumology, Center for Thrombosis and Hemostasis, University Medical Center Mainz, Mainz, Germany

¹⁶Department of Haemostasis Disorders and Internal Medicine, Institute of Hematology and Transfusion Medicine, Warsaw, Poland

¹⁷Division of Hematology and Oncology, Versiti Blood Center of Wisconsin, Medical College of Wisconsin, Milwaukee, Wisconsin, USA

¹⁸Institute of Hematology and Blood Transfusion, Prague, Czech Republic

¹⁹Department of Biostatistics & Epidemiology, College of Public Health, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, USA

²⁰Department of Pediatric Hematology and Oncology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

²¹Center for Thrombosis and Hemostasis, University Medical Center Mainz, Mainz, Germany

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Correspondence

Erika Tarasco, Department of Hematology and Central Hematology Laboratory, Bern University Hospital, Inselspital, CH-3010 Bern, Switzerland.

Email: erika.tarasco@insel.ch

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Abstract

Introduction: Severe COVID-19 is associated with an important increase of von Willebrand factor and mild lowering of ADAMTS13 activity that may, in the presence of a strong inflammatory reaction, increase the risk of acute thrombotic thrombocytopenic purpura (TTP). Although acute episodes of immune-mediated TTP associated with COVID-19 or SARS-CoV-2 vaccination have been reported, data about clinical evolution of hereditary TTP (hTTP) during the pandemic are scarce.

Method: We conducted a survey among adult patients of the International Hereditary TTP Registry about SARS-CoV-2 vaccination, COVID-19, and occurrence of acute hTTP episodes.

Results: Of 122 adult hTTP patients invited to participate, 86 (70.5%) responded. Sixty-five had been vaccinated (75.6%), of which 14 had received in addition a booster, resulting in 139 individual vaccine shots. Although vaccinations in patients on plasma prophylaxis were done within 1 week of the last plasma infusion, all 23 patients treated with plasma on demand were vaccinated without prior plasma infusions. One patient on uninterrupted weekly plasma infusions presented within 3 days from his second vaccination with neurological symptoms and computed tomography scan 9 days later showed subacute ischemic/hemorrhagic frontal lobe infarction. A second male patient developed acute myocarditis after his second dose of mRNA-1273 vaccine. Twelve (14%) patients had COVID-19, associated with an acute hTTP episode in three of them: one patient had a transient ischemic attack, one a stroke, and a pregnant woman was hospitalized to intensify plasma treatment.

Discussion: The risk of an acute episode triggered by COVID-19 seems higher than following vaccination in hTTP patients, who can be safely vaccinated against SARS-CoV-2.

KEYWORDS

COVID-19, congenital thrombotic thrombocytopenic purpura (cTTP), hereditary thrombotic thrombocytopenic purpura (hTTP), SARS-CoV-2, vaccines

Essentials

- Do COVID-19 or COVID-19 vaccination trigger acute episodes in hereditary thrombotic thrombocytopenic purpura (hTTP)?
- Survey of 86 adult hTTP patients from the International hTTP registry.
- One TTP event after 139 vaccinations (65 patients), 3 TTP events in 12 COVID-19-infected patients.
- hTTP patients can and should be vaccinated against SARS-CoV-2.

1 | INTRODUCTION

By the end of February 2022, the number of globally confirmed cases of COVID-19 had passed 435 million, and that of COVID-19-associated deaths 5.94 million.^{1–3} Effective vaccines have been developed and authorized over the past 2 years and are applied in ever-increasing numbers to control the SARS-CoV-2 pandemic.⁴

Hereditary thrombotic thrombocytopenic purpura (hTTP) is a rare autosomal recessively inherited disease, characterized by severe congenital ADAMTS13 deficiency, and acute hTTP episodes resulting in morbidity and premature death.^{5–8} Infections and to

a lesser extent vaccinations have been identified or suggested as triggers of acute hTTP episodes.^{6–8} Recently, Dykes and Kessler⁹ described the case of a 50-year-old female hTTP patient who had suffered from a number of acute cerebrovascular accidents over a period of 20 years. She was on plasma-prophylaxis with extended intervals of 4–6 weeks or even longer. Six weeks after a plasma infusion, she received her second dose of mRNA-1273 (Moderna) SARS-CoV-2 vaccine; 1 week later she presented with a new acute cerebrovascular accident with a generalized seizure. At that time, her platelet count was 98 G/L. So far, there are no reports of COVID-19 in hTTP patients.

Immune-mediated TTP (iTTP) is more prevalent than hTTP^{10,11} and a number of case reports and case series have described first acute iTTP episodes as well as relapses associated with COVID-19¹²⁻¹⁵ and with SARS-CoV-2 vaccination.¹⁶ Nevertheless, two comprehensive epidemiologic studies suggest that SARS-CoV-2 vaccination does not increase the risk of first episodes of iTTP, but may induce an acute iTTP bout or a relapse in asymptomatic subjects with a (severely) deficient ADAMTS13 activity.^{17,18} Patients with an iTTP diagnosis are usually followed up with regular ADAMTS13 activity measurements, and preemptive immunosuppressive treatment is started when ADAMTS13 activity drops to <15%–20% to avert a clinical iTTP relapse.^{10,11} At many centers, treating physicians have postponed SARS-CoV-2 vaccination in iTTP patients when ADAMTS13 activity was <20% and have tried to first correct ADAMTS13 activity levels, often with a course of steroids over 2–4 weeks. Although patients treated with anti-CD20 monoclonal antibodies (i.e., rituximab and others) can develop an immune response to SARS-CoV-2 vaccines, the risk of non-seroconversion following recent therapy and in patients with depleted B-cell pools is high.^{19,20}

In hTTP patients, ADAMTS13 activity <15%–20% is often present for prolonged times, even in patients on regular plasma prophylaxis.⁶⁻⁸ Whether withholding vaccination in hTTP patients, as proposed by Dykes and Kessler,⁹ is warranted should be further investigated. Therefore, we decided to conduct a survey on SARS-CoV-2 vaccination, COVID-19, and of associated possibly triggered acute hTTP episodes in adult confirmed hTTP patients followed in the International Hereditary TTP Registry.

2 | METHODS

Confirmed adult hTTP patients, having signed the informed consent of the International Hereditary TTP Registry (NCT01257269) were eligible for this study (Figure 1). Pediatric patients (<18 years of age) were not considered because recommendations and regulations regarding SARS-CoV-2 vaccination in children vary greatly among countries.

The survey was sent out mid-January 2022 to treating physicians and/or directly to the patients who were asked to respond within 30 days. The survey was built on yes/no and free text answers, with a “prefer not to answer” option for all questions. We recorded the SARS-CoV-2 vaccination status, number of doses administered and the product given, any vaccination-associated side effects, including acute hTTP episodes, their temporal onset in relation to vaccination, and the last plasma infusion.

In addition, we recorded COVID-19 cases, the associated clinical course, and the need for consultation, hospitalization, and additional plasma treatment during COVID-19.

The Cantonal Ethics Committee Bern (KEK #031/06) approved the Hereditary TTP Registry in 2006.

3 | RESULTS

Of 122 adult confirmed hTTP patients eligible to participate in this survey, 86 patients responded (Figure 1). The 52 female and 34 male patients had a median age of 40.24 years (range 18.22–75.86) and

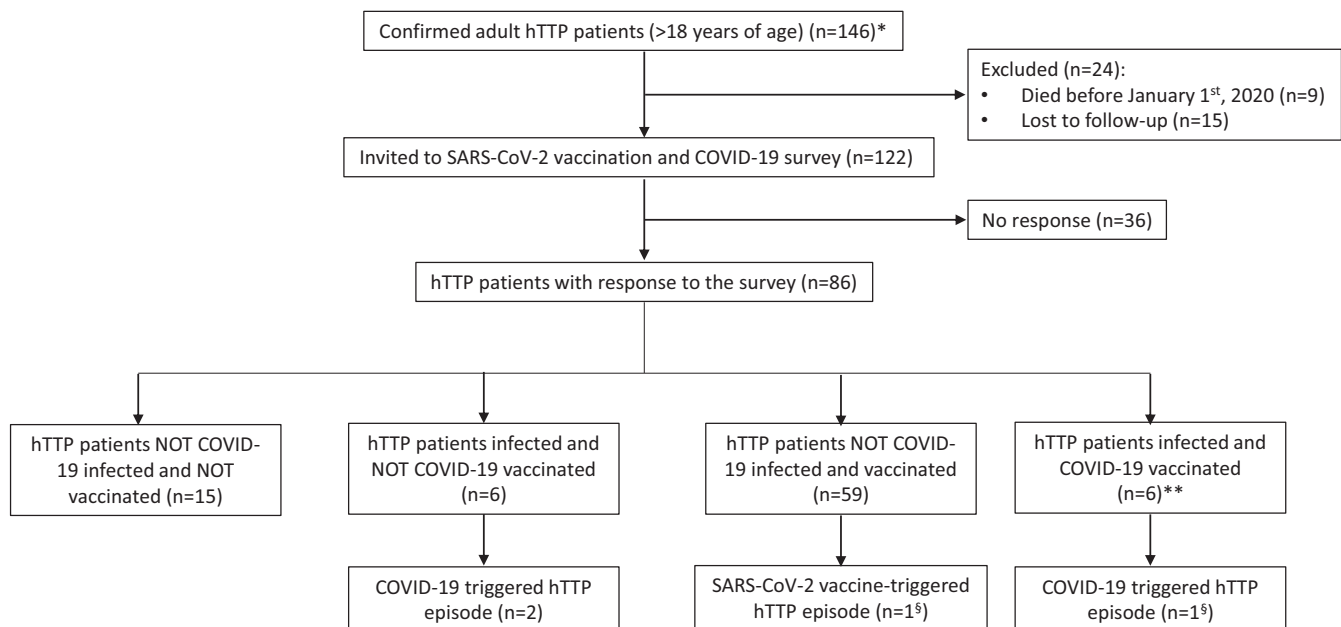


FIGURE 1 Study flowchart. Adult patients with a confirmed diagnosis of hereditary TTP in the International Hereditary TTP Registry at the end of January 2022. *Including 34 Japanese patients.²⁸ **Four of the six patients were vaccinated when suffering from COVID-19; two patients were vaccinated after COVID-19. †One patient had a COVID-19-triggered hTTP episode as well as a vaccination complication (myocarditis). hTTP, hereditary thrombotic thrombocytopenic purpura.

	n	N	%
hTTP patients invited to participate in survey	122		
hTTP patients responding to the survey	86	122	70.5
Not vaccinated	21	86	24.4
Vaccinated	65	86	75.6
Partially vaccinated ^a	2	65	3.1
Fully vaccinated ^a	63	65	96.9
Boosted ^a	14	63	22.2
Total vaccine doses administered ^b	139		
SARS-CoV-2 vaccine-triggered acute hTTP episodes (no. dose) ^c	1 (second)	139	0.7
SARS-CoV-2 vaccine-triggered other severe adverse event (myocarditis following second dose of mRNA-1273)	1 ^d	139	0.7
COVID-19 in hTTP patients	12	86	14
Outpatient treatment	10	12	83.3
Hospital admission	2	12	16.7
Intensive care unit admission or death	0		
COVID-19 triggered acute hTTP episodes ^c	3 ^d	12	25
COVID-19 triggered other severe adverse events	0		

TABLE 1 Survey on SARS-CoV-2 vaccination and COVID-19 in adult patients with confirmed hereditary TTP enrolled in the International Hereditary TTP Registry

Abbreviation: hTTP, hereditary thrombotic thrombocytopenic purpura.

^aPartially vaccinated: received one dose of mRNA vaccine; fully vaccinated: received two doses of mRNA vaccine (BNT162b2, mRNA-1273) or one dose of Ad26.COV.S; boosted: received a third dose of SARS-CoV-2 vaccine (either BNT162b2, mRNA-1273 or Ad26.COV.S).

^bFor three vaccinated patients, the product used was not retrievable; we assumed that they had received the minimum possible: one dose of vaccine.

^cThe possibly SARS-CoV-2 vaccine-triggered acute hTTP episode was severe (ischemic stroke, score 3⁸). The three acute hTTP episodes triggered by COVID-19 were moderate (transient ischemic attack, score 2), severe (ischemic stroke, score 3), and moderate (necessary hospitalization during pregnancy with intensification of plasma therapy, score 2), respectively.⁸

^dOne patient is presented twice. He had a COVID-19-triggered hTTP episode and then a complication following vaccination (myocarditis).

were mainly Caucasians (46/86, 53.5%) and Asians (30/86, 34.8%). Epidemiological and clinical characteristics of responding patients did not differ from those in patients who did not respond to our survey. Although 65 (75.6%) patients were vaccinated, 21 were not (Table 1). An mRNA-based SARS-CoV-2 vaccine was used in 61/65 (93.8%) patients, of which 83% received BNT162b2 (Pfizer/BioNTech) and 17% mRNA-1273 (Moderna). One patient was vaccinated with Ad26.COV2.S (Janssen/Johnson-Johnson). For three vaccinated patients, the product used was not retrievable. At the time of survey, 14 patients had received one SARS-CoV-2 vaccine booster shot in addition. Of the vaccinated patients, 41 were on regular prophylaxis (2–3 plasma units, every 7–21 days,⁸ a plasma-derived factor VIII product, or recombinant ADAMTS13); most of them received the vaccination within 1–3 days, and all within 1 week of prophylaxis. All 23 hTTP patients treated with plasma on demand were vaccinated without prior plasma infusions. We have no recent information on the plasma treatment for one patient.

Together, the 65 hTTP patients received at least 139 doses of SARS-CoV-2 vaccine (for the three patients without indication of product, we assumed that they had received the minimum of one

dose). The most common side effects reported were injection site reactions, fatigue, fever, and muscle and joint pain, and thus were similar to what had been described as side effects of BNT162b2, mRNA-1273, and Ad26.COV2.S before.^{21–23} Two male patients experienced complications, which were considered possibly or probably related to or triggered by the vaccine. One of them, a 52-year-old Caucasian, known for a history of severe hTTP with two prior ischemic strokes (one while on regular plasma prophylaxis), two transient ischemic attacks, and idiopathic venous thromboembolism, is on weekly plasma prophylaxis and regularly seen by his treating physician. On uninterrupted plasma prophylaxis, he was hospitalized with a normal platelet count for altered mental status with aggressive behavior 3 days after receiving his second dose of BNT162b2. Nine days later, a computed tomography scan showed a new ischemic infarction with a component of hemorrhage in the left frontal lobe. An additional 4 weeks later, during a planned plasma infusion, he experienced loss of function of his left arm with suspected stroke and platelet count dropped to 114 G/L. A new computed tomography scan showed no new lesions nor a thrombus. The next day, neurological symptoms had resolved. Thus, this patient with several prior ischemic cerebrovascular events

suffered from a possibly vaccine-triggered stroke within 3 days from his second dose of BNT162b2 and a transient ischemic attack 6 weeks later, despite weekly plasma prophylaxis.

The other patient, a 37-year-old Caucasian male on regular plasma prophylaxis, presented 14 days after his second dose of mRNA-1273 SARS-CoV-2 vaccine in August 2021 with chest pain. His complete blood count was normal with a platelet count of 183 G/L, high-sensitivity troponin T was 75 ng/L (normal <14 ng/L) at presentation and reached a maximum of 184 ng/L during the course. He had a normal coronary angiogram and echocardiogram. The further course was uneventful, and he was discharged 4 days later with a diagnosis of myocarditis, a recognized adverse reaction to mRNA-based SARS-CoV-2 vaccines.²⁴

Twelve of 86 (14%) hTTP patients participating in the survey reported to have suffered from COVID-19, of which four were vaccinated when infected and nine (75%) presented a mild course of COVID-19 infection. There were probably COVID-19-triggered acute hTTP episodes in three patients, all not vaccinated at the time, leading to hospitalization in two (Table 1). The first patient had mild thrombocytopenia when diagnosed with COVID-19 and noticed blurred vision (considered a transient ischemic attack⁸) later on without seeking medical help. The second patient, mentioned previously as having developed myocarditis following mRNA-1273 SARS-CoV-2 vaccination, had suffered from COVID-19 8 months earlier. At that time, he was admitted to the hospital with fever and an altered state of consciousness resulting from an ischemic stroke. During the hospitalization, he developed chest pain, dyspnea requiring oxygen supplementation, and hemoptysis. His high-sensitivity troponin T ranged from 3 to 32 ng/L during the stay. Besides plasma infusions, he received cephalosporin, fluconazole, and favipiravir and was discharged after 11 days without sequelae. The third patient, a 34-year-old Caucasian female, contracted COVID-19 in her 31st week of pregnancy and was hospitalized because of malaise, mild respiratory problems, and to better monitor the course of her disease and her pregnancy. Besides regular plasma infusions and anticoagulant therapy, she received casirivimab/imdevimab. She recovered within days and delivered a healthy baby by cesarean section in gestational week 37.

4 | DISCUSSION

The COVID-19 pandemic has emerged as a major health threat with constantly increasing numbers of confirmed cases and COVID-19 associated deaths.¹⁻³ Over the past 2 years, effective vaccines have been developed and large SARS-CoV-2 vaccination programs have been successfully implemented. A number of autoimmune phenomena and diseases have been described in the context of COVID-19¹⁵ and after SARS-CoV-2 vaccinations.²⁴ COVID-19 has been reported as a trigger for first episodes of iTTP as well as relapses¹²⁻¹⁵ and SARS-CoV2 vaccination was suggested also as a trigger of iTTP.¹⁶ Nevertheless, two epidemiologic studies clearly suggest that SARS-CoV-2 vaccination is unlikely to trigger new-onset iTTP.^{17,18}

Hereditary TTP is an ultra-rare disease characterized by a severe congenital ADAMTS13 deficiency resulting from biallelic ADAMTS13 mutations and recurring acute disease episodes associated with considerable morbidity and premature death.⁵⁻⁸ Infections are well known and common triggers of acute hTTP episodes, whereas vaccination-triggered episodes have been reported only occasionally.⁶⁻⁸ Inflammatory conditions and infections are associated with increased von Willebrand factor (VWF) levels and VWF-mediated thrombosis.²⁵ This mechanism is also implicated in severe COVID-19, where ADAMTS13 activity is often mildly reduced,^{26,27} and in microvascular thrombosis of acute TTP episodes where, in the absence of ADAMTS13 activity, ultra-large VWF multimers remain unprocessed and aggregate spontaneously with platelets.¹¹

Our survey documented 139 SARS-CoV-2 vaccination shots administered to 65 hTTP patients, of which one shot (0.7%) was possibly associated with an acute episode in a patient on regular plasma prophylaxis. This 52-year-old patient with several prior cerebrovascular infarctions suffered from a new stroke 3 days and from a transient ischemic attack 6 weeks after his second BNT162b2 vaccine shot. Because of the time window of only 3 days, the stroke may very well have been triggered by the vaccination. However, given the patient's severe and burdened medical history, the recurring stroke may also be explained by his severe congenital ADAMTS13 deficiency and his hTTP.

Most common side effects were injection site reactions, fatigue, fever, and muscle and joint pain. This is in line with findings in a smaller national cohort in Japan²⁸ and to what has been described globally as side effects of BNT162b2, mRNA-1273, and Ad26.COV2.S.²¹⁻²³ One grade 2 adverse event was documented in a male patient who developed myocarditis following the second dose of mRNA-1273.

As a precautionary measure, SARS-CoV-2 vaccinations were performed within 1 week of plasma infusion in all 41 patients on regular prophylaxis; of the 23 patients treated on demand, none received a plasma infusion before the SARS-CoV-2 vaccinations, and none experienced an acute hTTP episode.

On the other hand, three of 12 (25%) COVID-19 infections were associated with moderate to severe hTTP episodes,⁸ including a transient ischemic attack with mild thrombocytopenia, a stroke, and a hospitalization to intensify plasma treatment in a pregnant woman.

In conclusion, hTTP patients can be safely vaccinated against SARS-CoV-2, which seems to be beneficial because 25% of COVID-19 infections triggered important hTTP episodes. A prophylactic plasma infusion 1-3 days before the scheduled vaccination is an effective and reasonable precautionary measure, although may not be necessary in all patients.

AUTHOR CONTRIBUTIONS

E.T. and J.A.K.H. designed the survey and collected and interpreted data. E.T. wrote the first manuscript, which was revised by B.L. and J.A.K.H., A.S.v.K., R.H., T.B., T.I., P.N.K., E.H., O.P., S.F., O.G., P.K., N.H.S., C.v.A., and J.W. took care of the patients. A.S.v.K., K.F., I.H., P.N.K., R.S., M.M., J.N.G., and B.L. are members of the steering

committee of the International Hereditary TTP Registry providing advice and support. All authors provided editorial comments and approved the final manuscript.

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RELATIONSHIP DISCLOSURE

E.T. received congress travel support and/or lecture fees from Bayer, SOBI, and Takeda. All honoraria go to the employer, Insel Gruppe AG. R.H. received consultancy and advisory board fees, speaker honoraria from Takeda, Roche, Sobi, Octapharma, Novo-Nordisk, and Bayer. P.N.K. received consultancy and advisory board fees, speaker honoraria, and travel grants from Ablynx/Sanofi, Alexion, and Shire/Takeda. J.W. received grant support or lectures honoraria from Alexion, Alnylam Pharmaceuticals, Baxalta, CSL Behring, Ferring Pharmaceuticals, Novo Nordisk, Octapharma, Rigel Pharmaceuticals, Roche, Sanofi/Genzyme, Shire/Takeda, Sobi, and Werfen. K.D.F. received speaker honoraria from Siemens, has consulted for GUARDIAN Therapeutics, and has participated in an advisory board for Werfen. M.M. is a member of the advisory board of Takeda, Alexion, and Sanofi. B.L. is chairman of the data safety monitoring committees for the Baxalta 281102 and the TAK-755-3002 study (both investigating recombinant ADAMTS13 in hereditary TTP) and for the Takeda SHP655-201 study (recombinant ADAMTS13 in immune-mediated TTP), all three now run by Takeda. He is a member of the advisory board of Ablynx, now part of Sanofi, for the development of caplacizumab; and received congress travel support and/or lecture fees from Baxter, Ablynx, Alexion, Siemens, Bayer, Roche, and Sanofi. J.A.K.H. is a member of the advisory board of Shire, member of the Takeda group of companies, for the development of recombinant ADAMTS13, and of Ablynx, now part of Sanofi, for the development of caplacizumab. She received congress travel support and/or lecture fees from Ablynx/Sanofi, Bayer, Roche, SOBI, and Takeda. All honoraria go to the employer, Insel Gruppe AG. The remaining authors declare no competing financial interests.

ORCID

Erika Tarasco  <https://orcid.org/0000-0002-4387-8476>


Paul N. Knöbl  <https://orcid.org/0000-0002-7909-7225>

Eriko Hamada  <https://orcid.org/0000-0003-0913-2475>

Ingrid Hrachovinova  <https://orcid.org/0000-0003-0300-2063>

Masanori Matsumoto  <https://orcid.org/0000-0002-7243-3126>

Bernhard Lämmle  <https://orcid.org/0000-0003-4538-5154>

Johanna Anna Kremer Hovinga  <https://orcid.org/0000-0002-1300-7135>

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