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LETTERS

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Factors influencing severe COVID-19 in systemic vasculitis patients: comment on the article by Rutherford et al

To the Editor:

We read with great interest the article by Dr. Rutherford and colleagues on the risk factors for severe COVID-19 in patients with systemic vasculitis (1). This has been the first report to describe the features of COVID-19 among a vasculitis-specific cohort. We would like to address several points of interest.

First, 9% of patients with COVID-19 in this study had a negative SARS–CoV-2 polymerase chain reaction test result. Viral (including influenza) (2,3) and bacterial (4) coinfections and various opportunistic superinfections (5) have been reported in the literature. Were these cases investigated for other causes of respiratory infections?

Second, vasculitis disease activity was determined using the physician's global assessment of disease activity. Given that the majority (85%) of the COVID-19 cases were among patients with antineutrophil cytoplasmic antibody–associated vasculitis, validated scoring systems such as the Birmingham Vasculitis Activity Score (6) and its modification for granulomatosis with polyangiitis (7) could have been used to denote the level of disease activity.

Finally, no further information regarding the patients who died was provided in the report. For instance, given that the rate of active disease was high among these patients, did any of them die due to the complications of active vasculitis (rather than COVID-19)?

Author disclosures are available at https://onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1002%2Fart.42022&file=art42022-sup-0001-Disclosureform.pdf.

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Reply

To the Editor:

We are grateful to Drs. Kardaş and Küçük for the interest shown in our article and for their comments. We are happy to supply additional information to address the questions posed.

First, we would like to provide clarification on the comment "9% of patients with COVID-19 in this study had a negative SARS–CoV-2 polymerase chain reaction result." Of the patients in our study population, 9% (6 of 65 patients) were reported as having clinical or radiologic evidence supporting the diagnosis of COVID-19, but information regarding whether a polymerase chain reaction (PCR) test was undertaken for these patients was not available to us except in the case of 1 patient who did have a negative test result at the time of case report form submission. However, the reporting physicians were confident in the diagnosis based on relevant features identified by clinical examination and computed tomography scan.

Regarding whether cases were investigated for other causes of respiratory infections, reporting physicians were asked about the presence of concomitant respiratory tract infection. In the 28% of patients (18 of 65) who did not have a definite PCR-confirmed diagnosis, no other specific respiratory pathogens were reported. Of those patients, 4 of 18 had secondary, presumed bacterial pneumonia. However, data in this section of the case report form were missing for approximately one-half of the patient population.

The Birmingham Vasculitis Activity Score (BVAS) instrument (1) was available for the reporting physician to complete, but it was an optional component of the case report form due to the