# Correspondence on: 'What comes after the lockdown? Clustering of ANCA-associated vasculitis: single-centre observation of a spatiotemporal pattern'

It was with great interest that we read the article by Gauckler *et al* titled 'What comes after the lockdown? Clustering of ANCA-associated vasculitis: single-centre observation of a spatiotemporal pattern', published in *Ann Rheum Dis* in December 2020.[1] Its authors reported a twofold increase of the incidence rate of antineutrophil cytoplasmic antibodies (ANCA)-associated vasculitis (AAV) diagnoses and a threefold increase in incidence rate of de novo AAV manifestations at their centre compared with previous years. Furthermore, they found the clustering of cases following the end of the pandemic's first wave. The increase in the incidence could not be attributed to a deferral of symptoms or delayed diagnoses.

Indeed, the SARS-CoV-2 virus pandemic significantly affected our daily rheumatological routine and the management of systemic vasculitides. We had to adjust our daily practice practically overnight, finding new ways to take optimal care of our patients. Therefore, how successful were we in managing patients with systemic vasculitides? At our secondary/tertiary rheumatological department, for the past decade we have been following the variations in the frequency, delays to diagnosis (the symptom duration time until diagnosis) and the baseline activity of the most commonly diagnosed vasculitides, that is, giant cell arteritis (GCA), IgA vasculitis and AAV. In the present study, we examined whether these characteristics have changed significantly during the COVID-19 pandemic. In 2020, we diagnosed a total of 79 new adult cases of GCA, IgAV and AAV (30, 28 and 21 cases, respectively). Temporal variations of GCA, IgAV and AAV over the last decade (2010–2020) are presented in the online supplemental figure S1A. Table 1 shows the median (IQR) symptom duration time and disease activity at presentation. In spite of the COVID-19 pandemic, neither was the symptom duration time longer nor was the baseline disease activity higher (determined by the Birmingham vasculitis activity score (version 3)[2] for small vessel vasculitides, and by permanent vision defects) in 2020 compared with the previous decade (2010–2019). In addition, we did not observe the clustering of vasculitides after the end of spring lockdown in May 2020 as reported by Gauckler *et al*[1] (online supplemental figure S1B). Our experience with GCA is in fact quite the opposite to that reported by Luther *et al*, who recently identified an increase of GCA cases as well as of cases with visual impairment during the COVID-19 pandemic.[3]

In conclusion, our experience shows that patients with systemic vasculitis sought help and did not suffer from significant delays in receiving healthcare even during the pandemic.

**Table 1** Characteristics of vasculitides before and during COVID-19 19 pandemics year 2020

| | Symptom duration time* (weeks) | | Disease activity/severity† | |
|---|---|---|---|---|
| Vasculitis | 2010–2019 | 2020 | 2010–2019 | 2020 |
| GCA | 4.3 (3.0–8.6) | 4.3 (2.0–6.9) | 10.0% | 10.0% |
| AAV | 13.0 (5.2–36.1) | 10.9 (5.6–21.7) | 16 (11–22) | 11 (6–21) |
| IgAV | 1.0 (0.7–2.3) | 1.6 (0.9–3.0) | 8 (3–14) | 8 (5–14) |

*Median and IQR.
†Determined as BVAS-3 (median, IQR) in IgAV and AAV, and as percentage of patients with permanent vision defect in GCA.
AAV, ANCA associated vasculitis; GCA, giant cell arteritis; IgAV, IgA vasculitis.

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Figure S1. Panel A) Annual fluctuation in the frequency of giant cell arteritis, ANCA-associated vasculitis and IgA vasculitis. Panel B) Monthly fluctuation in the frequency of giant cell arteritis, ANCA-associated vasculitis and IgA vasculitis during period 2010 to 2019 and in year 2020.