Correspondence on 'Increased risk of systemic lupus erythematosus in patients with autoimmune haemolytic anaemia'

With great interest, we read the recent article by Mo *et al* regarding the association between autoimmune haemolytic anaemia (AIHA) and the subsequent development of systemic lupus erythematosus (SLE) based on a nationwide population-based cohort.¹ In this study, the authors found that patients with AIHA had an increased risk of SLE (HR 54.67; 95% CI 22.33–133.89). We appreciate Mo *et al*'s work on this group of patients with a high risk of developing SLE, which should be more carefully managed in the future, however, we would like to address some points.

First, previous studies have indicated that patients with childhood-onset SLE were more likely to have AIHA compared with adulthood-onset ones.^{2–3} Therefore, we suggest that the authors should describe the incidence of AIHA in different age populations, which is interesting and may be clinically valued.

Second, the haematological system is often involved in SLE, which may manifest as one or more lineages of haemocytopenia. Thrombocytopenia was reported to be independently associated with the severity of AIHA in patients with SLE.⁴ Zhu *et al* in their retrospective study based on the same population cohort even demonstrated that the patients with idiopathic thrombocytopenic purpura (ITP) had a 26-times higher risk of new-onset SLE compared with the control population.⁵ Therefore, we suggest that the authors should investigate the difference in the incidence of SLE between patients with both AIHA and ITP and those with either AIHA or ITP. Besides, it has been proposed that both AIHA and autoimmune thrombocytopenia are associated with antiphospholipid antibodies, suggesting the presence of antibodies against the epitopes on the red cell membrane and platelets, probably the shared mechanisms in their pathophysiology.^{6–7} Therefore, the laboratory data of antiphospholipid antibodies will be of interest and probably important.

Finally, we noted that the HRs were extremely high with a wide range of 95% CI values (eg, 95% CI 91.15–235.84) in the study. Based on a nationwide population cohort study, all the patients with AIHA were identified by searching the International Classification of Diseases, Ninth Revision (ICD-9) code, which would inevitably lead to selection bias. Some patients presenting with AIHA may have been in the early stage of SLE, however actually included in the AIHA group in the study. The authors should at least check the autoantibodies to make sure the diagnosis of AIHA. Furthermore, the low incidence rates of SLE in the non-AIHA control group as well as insufficient consideration of risk factors strongly related to developing SLE in the database may also have contributed to the bias.⁸ Time-varying effect analysis to show the adjusted HR in different time intervals from AIHA to SLE diagnosis may be helpful.

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