

Correspondence

Reply

To the Editor:

We thank Kiani-Alikhan and coworkers¹ for their interest in our Current Perspective article. As we pointed out, we think that IgG therapy should never be withheld from an IgA-deficient patient solely because of concern for the theoretic risk of a rare serious adverse reaction.² There are insufficient data to warrant a general recommendation for screening for anti-IgA antibodies in these patients. The scarcity of case reports describing anaphylaxis from immunoglobulin therapy in IgA-deficient patients does not support the significantly heightened concern widely spread in the medical community about the use of blood products including intravenous immunoglobulin (IVIG) in IgA-deficient subjects. The role of anti-IgA antibodies in triggering such reactions requires further evaluation.

Kiani-Alikhan and coworkers describe the interesting case of a patient with common variable immunodeficiency who not only tolerated the high IgA (6 mg/mL) and IgM (6 mg/mL)-containing immunoglobulin infusion administered intravenously but also benefited from it, as her rate of infections decreased markedly compared with when she was on another IVIG product. They conclude that an infusion containing IgA and IgM may actually provide increased therapeutic effects. However, the IgA and IgM serum levels for this patient were not reported. There are few other articles in the literature describing benefits from IVIG containing high IgA and/or IgM. In a German study, patients who underwent cardiac surgery and were treated with such a solution continuously for 53 hours postoperatively had a significantly lower rate of incidence of infection compared with those treated with placebo (physiologic saline).³ However, this was not compared with a group of patients receiving an IVIG infusion containing low IgA, and so the benefit cannot be stated to be from IgA or IgM *per se*. In another study, 41 patients undergoing cardiac bypass received an IVIG solution with elevated IgM content and

developed fewer signs of inflammation (fever, hypotension, and leukocytosis) and had a reduced hospitalization period postoperatively than did those receiving placebo.⁴

Larger studies are required to evaluate the safety and efficacy of the immunoglobulin infusion with high IgA and/or IgM content in preventing infections in general, and in immunodeficient patients in particular. The safety of gammaglobulin infusions containing a low to moderate content of IgA should preferably be established first in IgA-deficient patients before evaluating the therapeutic effects of immunoglobulin with high IgA content.

Rima Rachid, MD

Francisco A. Bonilla, MD, PhD

From the Division of Allergy/Immunology, Children's Hospital Boston, Harvard Medical School, Boston, Mass. E-mail: Rima.rachid@childrens.harvard.edu.

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