

CORRESPONDENCE

PF4 Immunoassays in Vaccine-Induced Thrombotic Thrombocytopenia

TO THE EDITOR: In a recent study, Greinacher et al.¹ reported thrombotic complications, mostly cerebral vein thrombosis, associated with thrombocytopenia in 11 patients after they had been vaccinated with ChAdOx1 nCoV-19 (AstraZeneca). Although none of these patients had received heparin, the authors detected high titers of anti–platelet factor 4 (PF4)–heparin antibodies that strongly activated platelets in vitro without heparin and in the presence of PF4. This syndrome, which resembles autoimmune heparin-induced thrombocytopenia, was called vaccine-induced immune thrombotic thrombocytopenia (VITT), and an algorithm for the management of this syndrome was proposed on the basis of immunoassays detecting anti–PF4–heparin antibodies.

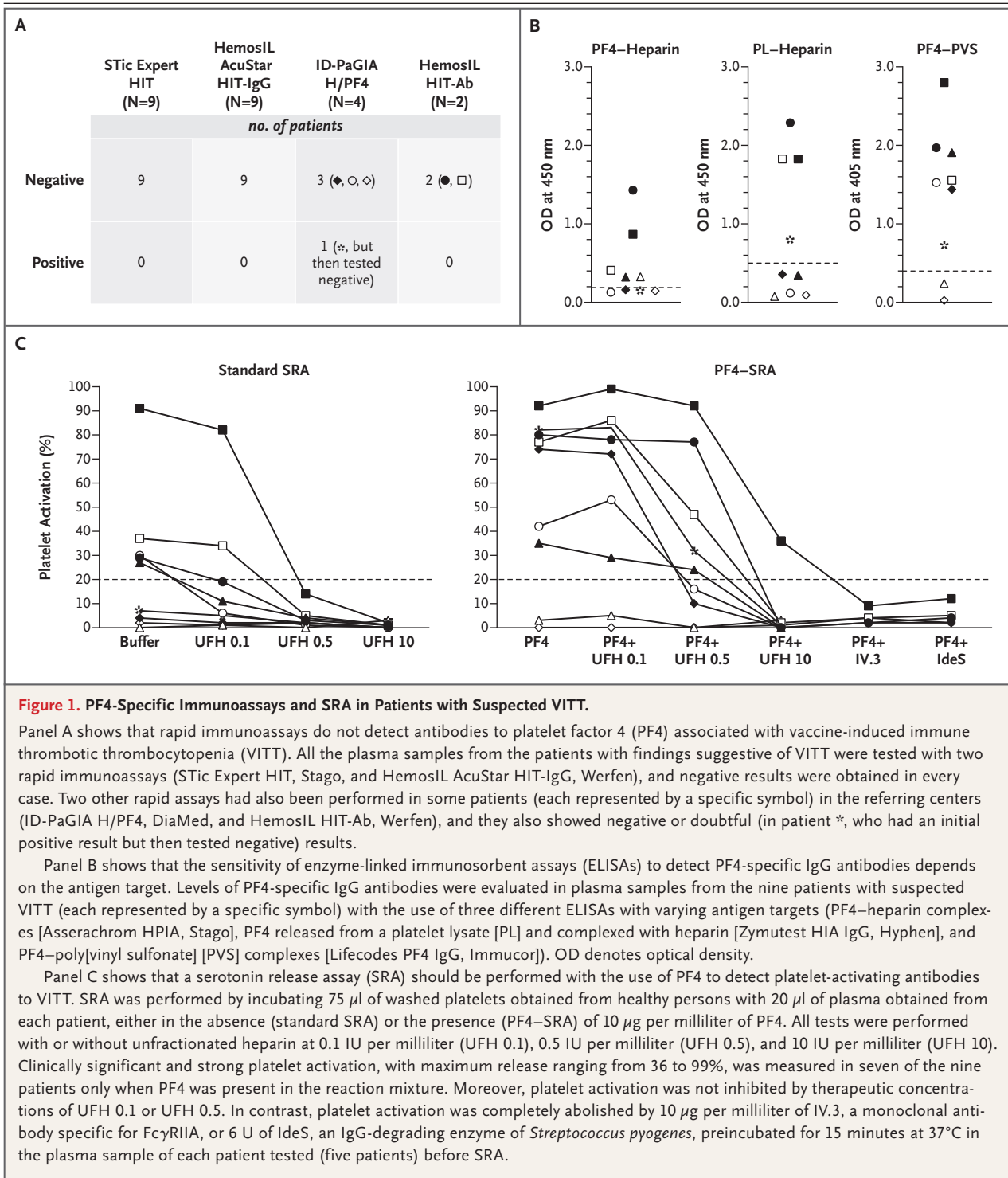
Between March 19 and April 1, 2021, plasma samples from nine patients (median age, 44 years) with suspected VITT after vaccination with ChAdOx1 nCoV-19 were analyzed in our laboratory (Table S1 in the Supplementary Appendix, available with the full text of this letter at NEJM.org). Cerebral vein thrombosis (in six patients) and splanchnic vein thrombosis (in five patients) were the most common events. All the patients had severe thrombocytopenia (median platelet count nadir, 29,000 per cubic millimeter; range, 9 to 61,000) except for one woman with both cerebral vein thrombosis and splanchnic vein thrombosis. Two rapid immunoassays widely used for the diagnosis of heparin-induced thrombocytopenia (STic Expert HIT and HemosIL AcuStar HIT-IgG) were performed on plasma samples to detect PF4-specific antibodies, and the results were negative in all the patients. Two other rapid tests had been performed in some patients by the referring laboratories and were negative, except in one patient, who had an equivocal result (Fig. 1A).

We also tested all plasma samples with three different PF4-specific enzyme-linked immuno-

sorbent assays and obtained variable results (Fig. 1B). Significant levels of IgG antibodies to PF4 were detected in seven patients only by the assay that used PF4–poly(vinyl sulfonate) (PVS) complex as the antigenic target. In addition, optical density values were variable and lower than those previously reported with a similar test.² The diagnosis of VITT was confirmed by PF4–serotonin release assay³ in all seven patients with IgG antibodies to PF4–PVS (Fig. 1C), whereas a standard serotonin release assay was negative in two patients. Platelet activation was suppressed by IV.3, a monoclonal antibody that binds FcγRIIA receptors, but also by IdeS (IgG-degrading enzyme derived from *Streptococcus pyogenes*) (Fig. 1C), a protease that also inactivates heparin-induced thrombocytopenia IgG antibodies.⁴ Intravenous immune globulins may be inappropriate for severe cerebral vein thrombosis with intracranial hypertension. IdeS (imlifidase) may be an effective treatment and needs to be evaluated.

Our results provide further support to show that rapid immunoassays should be avoided in the detection of PF4-specific antibodies in patients with suspected VITT. Therefore, the use of a sensitive, quantitative, immunologic test is strongly recommended, because according to the recently proposed algorithm,^{1,5} nonheparin anticoagulants should be preferred when clinically significant levels of anti-PF4 antibodies are detected.

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Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.

This letter was published on May 19, 2021, at NEJM.org.

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DOI: 10.1056/NEJMc2106383

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