

effects were reported. The patient improved progressively, and on dismissal 7 days later, he was afebrile and not hypoxic. At follow-up, he remained afebrile, with normal oximetry results, and imaging revealed almost complete resolution of pulmonary infiltrates (Figure 1 E and F). He also had a negative SARS-CoV-2 RNA test result 1 month after his last hospitalization and 305 days after his first positive test result. He has subsequently received monthly outpatient infusions of Vax-plasma, and after 10 weeks of follow-up, the patient has not been admitted to the hospital.

To our knowledge, this is the first report of Vax-plasma treatment in a patient with COVID-19 unable to mount normal antibody responses to the disease. Notably, the serum neutralizing antibody response from individuals who have been infected is enhanced after receiving a messenger RNA vaccine and could effectively neutralize an array of COVID-19 variants.^{7,8} In conclusion, the use of Vax-plasma is a promising therapy that can be included in the treatment and prevention of COVID-19 in immunocompromised patients.

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Giant Cell Arteritis: The Place of ¹⁸F-FDG PET/CT and Serum Haptoglobin Level



To the Editor: I read with great interest the article by Garvey et al.¹ They mentioned that treatment with tocilizumab induced a direct inhibition of the acute phase response, and thus C-reactive protein levels are difficult to interpret. This is why identifying active disease or relapse is a challenge in these patients. ¹⁸F-Fluorodeoxyglucose positron emission tomography/computed tomography (¹⁸F-FDG PET/CT) has been proposed as a useful tool to assess response and relapse. However, several studies reported that a complete normalization of PET/CT activity occurred in less than 30% of patients while they are in clinical remission.^{2,3} The place of ¹⁸F-FDG PET/CT in follow-up should be further investigated. Recently,

Unizony et al.⁴ studied several biomarkers in the sample from patients of the Giant Cell Arteritis Actemra trial.⁵ They included 30 patients with active disease (16 taking prednisolone and 14 taking tocilizumab). Serum amyloid A1 and A2 and complement factor H were higher in patients with active disease and receiving prednisolone therapy. Interestingly, the haptoglobin blood test, which is an easy and widely available biological test, seems to be higher in patients with active disease and taking tocilizumab. This may be helpful as tocilizumab use will be substantially increased in the next few years. More studies are needed to evaluate the place of ¹⁸F-FDG PET/CT and serum haptoglobin level in follow-up and in the diagnosis of relapse.

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