problem at the follow-up visit performed one month later (1). Considering the shipment date of the article, it is understood that at least two years have passed after the patient's discharge. Reporting of the developments which have occured during this period and if the patient currently receives medication will be beneficial for us, clinicians.

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Re: Current treatment options for severe autoimmune hemolytic anemia

Dear Editor,

We thank the valuable author for their opinions and recommendations related to our article. We would primarily like to report that our patient is in remission and recurrence has not occurred. The patient is still being followed up by us and the hemoglobin, reticulocyte, and bilirubin levels have been found to be normal, the direct Coombs test became negative and has not become positive again.

The author mentioned the treatment methods recommended for cold agglutinin disease, which is a type of autoimmune hemolytic anemia (AIHA). This disease, observed mostly in adults, is a chronic lymphoproliferative disease that develops idiopathically or secondary to other diseases including malignancy (1). At this point, we would like to emphasize that our patient had AIHA secondary to infection rather than cold agglutinin disease. As we mentioned in the first sentence of the part Discussion, AIHAs that develop secondary to infection mostly occur 2-3 weeks after onset of infection and recover spontaneously in 2-3 weeks (2). Negative Coombs test and lack of development of hemolysis during the follow-up supports that our patient did not have cold agglutinin disease.

Autoimmune hemolytic anemia may have a fatal course and the type of treatment should be specified according the severity and speed of development of anemia. There is no standard therapeutic approach because randomized controlled studies in children are lacking. Antibody specification tests are time-consuming procedures in children presenting with a clinical picture of autoimmune hemolytic anemia. Therefore, it is important to initiate treatment urgently until antibody specification tests are completed. Treatments administered in the acute phase include transfusion of erythrocyte suspension, corticosteroids and intravenous immunoglobulin (3). Corticosteroid treatment is mostly recommended in warm antibody AIHA (3). In a large-scale study conducted with children with autoimmune hemolytic anemia, it was reported that complete remission was obtained in 58% of the children with steroid treatment alone (4). In another recent study recently, it was reported that a good response to steroid was obtained in children regardless of the type of AIHA (5). The role of intravenous immunoglobulin in treatment is controversial. It has been recommended to consider the use of intravenous immunoglobulin G (IVIG) in patients who are resistant to steroid treatment (3). However, one of the main determinative factors in treatment is the type of antibody. In cold antibody AIHA, avoidance from cold and therapeutic plasma exchange are recommended as the first-line treatment and rituximab is recommended as the second-line treatment (3). On the other hand, cold agglutinin disease/cold antibody AIHA are included in the category II disease group; therapeutic plasma exchange is recommended alone or in combination with other treatments as the second-line treatment in this group of diseases according to the guidelines of the American Society for Apheresis (ASFA) Apheresis Applications Committee, published in 2016 (6).

In conclusion, AIHA may have a fatal prognosis in children. Prompt treatment is necessary. It would be appropriate to make treatment decision according to the clinical course and treatment response.

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