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| **Case report author** | **Age** | **Gender** | **Ethnicity** | **Past medical history** | **IgA vasculitis presentation/criteria** | **CBC, CMP, PT, PTT, inflammatory markers** | **UA** | **Other ancillaries** | **COVID-19 diagnosis** | **WHO causality assessment** | **Outcome** |
| AlGhoozi et al (2021) | 4 years | M | Not specified | Previously healthy | Palpable purpura in LE, bilateral ankle arthritis | All normal | Normal | Negative titers for ASO, ANA, anti-ds DNA. Normal serum IgA levels | PCR +, 37 days prior | Possible | At 1 week follow-up rash was still present bilaterally and urine dipstick revealed trace blood but RBCs were 0-2. He was given another appointment in 2 months for follow up. |
| Al Haiji et al (2021) | 13 years | F | Mediterranean | Previously healthy | Palpable purpura in LE, abdominal pain, bilateral ankle arthritis | Elevated ESR, CRP, rest normal | 5 WBC | Pathology showed leukocytoclastic vasculitis, no immunofluorescence done | PCR + on presentation (2 weeks after onset of purpura) | Possible | Follow up 2 weeks after revealed no episodes of abdominal pain or fever and excellent improvement with abnormal results revert back to normal at 6 weeks post discharge |
| Bekhit et al (2021) | 5 years | F | Mediterranean | Atopic dermatitis | Palpable purpura in LE, bilateral ankle arthritis | CBC with leukocytosis, elevated CRP, ferritin and D-dimer. | Normal | Elevated IgA levels | PCR +, 4 days after onset of purpura | Possible | Patient was discharged with completely resolvedarthritis on the 6th day, while skin manifestations resolved on follow-up at the outpatient clinic (on day 14) |
| Borocco et al (2021) | 13 years | F | Mediterranean | Suprasellar germinoma, panhypopituitarism | Palpable purpura in LE and buttocks, bilateral ankle arthritis, abdominal pain | CBC with leukocytosis , elevated CRP. | Normal | EBV PCR positive, elevated serum IgA levels | PCR + 13 days after initial presentation | Possible | She had no complications from Covid-19 or IgA vasculitis at follow up and did not present with IgA vasculitis nephritis at the 1-year follow-up. |
| El Hasbani et al (2021) | 16 years | M | Caucasian | Not specified | Palpable purpura, abdominal pain,hematochezia | Elevated CRP, ESR, D-dimer. | Proteinuria | Elevated serum IgA levels | PCR + 2 days prior | Probable/  likely | COVID-19 test became negative 11 days after the initial positivity. Two weeks later, 24-hour urine collection showed less proteinuria (2870 mg/24 hours). Six weeks later, the rash had faded and a 24-hour urine protein had decreased to 780 mg. |
| Gogeascoecheae t al (2021) | 6 years | M | Hispanic | Previously healthy | Palpable purpura, unilateral ankle edema, abdominal pain | Elevated D-dimer and ALT (3x). Prolonged PTT. | Normal | Negative LA, anti-beta2 glycoprotein,anticardiolipin antibodies | PCR + on presentation | Possible | 15 days after discharge, inflammatory markers normalized and the patient had no evidence of IgA nephritis. |
| Hoskins at al (2021) | 2 years | M | Hispanic | Previously healthy | Palpable purpura with predominance on UE (sparing hands, feet, trunk). Abdominal pain, vomiting, hematochezia | Mild anemia, elevated D-dimer. | Normal | PCR of stool negative, abdominal US negative for intussusception, appendicitis, adenitis. Normal echocardiogram. EGD showed erosions on stomach and duodenum. Pathology of skin lesions showed leukocytoclastic vasculitis, positive IgA immunostain | PCR + on presentation | Possible | Discharged home after improvement. No follow-up recorded |
| Jacobi et al (2021) | 3 years | M | Not specified | Hirschprung’s disease | Purpura in LE, buttocks, elbows, nonbilious emesis, abdominal pain | Mild anemia and thrombocytosis. Did not mention inflammatory markers. | Normal | VBG with mild metabolic acidosis. Abdominal US with fluid filled loops of bowel. Abdomen XR with with thickened bowel wall. | PCR + on admission | Possible | Discharged home after improvement. No follow-up recorded |
| Nakandakari et al (2021) | 4 years | M | Hispanic | Previously healthy | Purpura in LE including soles. Petechiae in lower labial mucosa, abdominal pain, hematemesis | Normal | Normal | Strongyloides (+) in fecal study | IgM (+) on admission | Possible | Discharged home upon improvement. No follow-up recorded |
| Kumar et al (2021) | 13 years | M | Black | Previously healthy | Purpura in LE | Mildly elevated ESR, elevated D-dimer. | Moderate hematuria | Elevated IgA level. Normal C3, C4. Skin biopsy showing small vessel neutrophilic vasculitis. No IgA deposits found | PCR positive 4 weeks prior | Possible | Child gradually improved but still had some persistent  lesions for almost 4 weeks |
| RIscassi et al (2021) | 3 years | M | Caucasian | Previously healthy | Purpura in LE and hands. B/L knee arthritis | Normal WBC, anemia, normal platelets, slight increase ESR, CRP and procalcitonin | Microhematuria and mild proteinuria | High fibrinogen and D-  dimer. Normal troponin, proBNP, C3, C4. ANA +, CXR, EKG and echo unremarkable | PCR positive on admission | Possible | After 3 weeks, marked improvement with almost total regression of the skin rash was observed. Patient is continuing monthly urine analysis. |
| Ziyara et al (2021) | 12 years | M | South Asian | Previously healthy | Abdominal pain followed by purpura in LE | CBC with leukocytosis. Elevated CRP, ESR, D-dimer. Rest normal | Normal | Abdominal US unremarkable | PCR and IgG+ on admission | Possible | On 2-week outpatient follow up, the child had improved and his rash faded. He re-presented one month later with a further episode of abdominal pain, loose stools and re-emergence of his rash. UA normal. He re-presented 2 months after initial episode with arthritis of the small joints of the hand bilaterally. Repeated SARS-CoV2 PCR was negative. |
| ANA- antinuclear antibodies, CBC- complete blood count, CRP- C-reactive protein, CXR- Chest X-ray, ESR- erythrocyte sedimentation rate, US- ultrasound. \*\*CMP includes renal and liver function test | | | | | | | | | | | |

*Table 2. Patient characteristics per included study*