LETTER TO THE EDITOR

Reply to Dr. Caprilli et al.’s letter

Dear Sir,

First of all we would like to thank Professor Caprilli for his interest in our work. We totally agree with his statement that surgery continues to have an important place in the management of severe ulcerative colitis, even in the era of biological therapies. However, the results of our study1 and the study from Rome2 cannot be compared as they consisted of two totally different populations. In our paper outpatients with moderate-to-severe refractory ulcerative colitis were studied, while the study by Aratari et al. consisted of inpatients with severe intravenous (IV) steroid-refractory colitis.

Aratari et al. reported a colectomy rate of 18% in patients with severe IV steroid-refractory colitis who received infliximab (IFX), while we reported a colectomy rate of 17% during a median follow-up of 33 months in outpatients who received IFX for refractory moderate-to-severe colitis. Although one might expect a higher short-term colectomy rate in severe IV steroid-refractory colitis, there are no scientific data to support this. If short-term response to IFX is achieved in patients with severe IV steroid-refractory colitis and if IFX is continued in a maintenance setting thereafter, probably the same outcome can be expected as in outpatients with moderate-to-severe disease who receive the same treatment schedule.

We also like to point out to the difference in sample size between both studies. The Roman trial included only 11 patients who received IFX, making it difficult to extrapolate the results. Furthermore, it is not clear if the follow-up period was indeed comparable, since the reported median follow-up of 26 months in the Roman study was the follow-up period of the whole cohort, including patients with IV steroid-refractory colitis who did not receive IFX.

In the meanwhile in our center we have treated nine patients [median (range) age at first IFX 37.5 (9.1–43.8) years, 3 female] with IFX for severe IV steroid-refractory colitis (unpublished data). A complete short-term clinical response was seen in 6 out of 9 patients and one more patient achieved clinical response after a second infusion with IFX eight weeks later. Two patients needed colectomy after 1.6 and 2.2 months, respectively. During a median follow-up of 17.0 months, none of the remaining seven patients needed colectomy. Six had sustained clinical response through-out follow-up. Three could stop IFX after bridging to azathioprine and another three patients are still under maintenance therapy. In one patient, azathioprine was added after seven months because of clinical relapse.

To conclude, we think that both the Italian study as well as our own study do not allow to exactly assess the influence of IFX on colectomy rates since both studies are retrospective and do not include a control arm. However, it is expected that the long-term follow-up of the ACT1&2 trials will shed more light on long-term outcomes including colectomy rates. Preliminary data presented during the UEGW 2007 in Paris showed a significant lower colectomy rate in patients who received IFX compared to patients who received placebo (9.5 vs. 14.8%, p=0.035)3. Furthermore, this significant difference is probably underestimated since patients in the placebo group could be rescued with IFX.

References


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