LETTER TO THE EDITOR

Reply to Dr. Kotze's and Dr. Yamamoto's letter

Dear Sir,

We appreciate the opportunity to reply to Dr. Kotze's and Dr. Yamamoto's letter about our paper “Prevention of postoperative recurrence with azathioprine or infliximab in patients with Crohn's disease: an open-label pilot study”, recently accepted for publication in JCC.

We agree with the first comment concerning the hypothesis that the use of anti-TNF (tumor necrosis factor)-α before surgery could control disease activity in the long term. This remains only a hypothesis, however, since no formal study has focused on this issue so far, in particular more than one year after anti-TNFα discontinuation. Also in the study by Regueiro et al., 5 of 13 patients treated with placebo have been previously treated with infliximab and rates of endoscopic recurrence in that group was high (84.6%).

In our study, the presence of active perianal disease at time of surgery was an exclusion criteria. The evaluation of perianal fistulas was only clinical at enrollment, as in most of the trials evaluating medical treatment in perianal disease. However, all patients with history of perianal disease included in our study also had the most recent pelvic radiological examination negative for active disease.

We agree with Dr. Kotze and Dr. Yamamoto about the very interesting possibility to plan a study focused on medical prevention of radiological recurrence in patients undergoing ileocecal resection, considering that Crohn's disease (CD) has a transmural involvement. However, the gold standard for the definition of postoperative recurrence is currently based on endoscopic findings and this is why the primary outcome in our study was the prevention of endoscopic recurrence.

We also agree about the need of larger studies to find the better treatment for the prevention of postoperative recurrence in CD. Twenty-two patients are few, but our study represents the first direct comparison between azathioprine and infliximab, and may be considered as an incentive to extend this evaluation to a greater number of patients.

Subjects pre-operatively treated with biological therapy could represent a "high risk" subgroup for postoperative recurrence, supposing that their disease activity could be more aggressive to justify the indication to start anti-TNFα in comparison with those receiving only conventional treatments.

As suggested by Kotze and Yamamoto, it could be interesting to analyze endoscopic and clinical outcomes when this particular subgroup of patients continues or not anti-TNFα treatment after surgery.

Considering all risks and benefits of combination therapy and the current debate about its use in active CD, we think that it is still premature to imagine its administration as preventive therapy in patients who are "disease-free" after surgery. In the future, we will be probably able to standardize an ideal personalized schedule of treatment for prevention of postoperative recurrence analyzing more reliable risk factors.

Conflict of interest statement

AA received: consultancy from Abbvie, MSD; lecture fees from Abbvie, MSD, Chiesi, Ferring, Nycomed, Otsuka; educational grants from Abbvie, MSD, Ferring, Nycomed. CF: nothing to declare.

References


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