ACKNOWLEDGEMENT

Declaration of personal and funding interests: None.

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doi:10.1111/j.1365-2036.2010.04365.x

Erythropoietin adjuvant therapy and sustained virological response in HCV-infected patients

Sirs, We read with interest the review article by MacNicholas *et al.*[1] addressing the role of erythropoietin in the management of anaemia caused by peginterferon and ribavirin (PEG/RVB) during treatment of HCV infection. They concluded that the effect of erythropoietin on sustained virological response (SVR) is not clear. This conclusion is based on the nonsignificant results of studies that either compared patients with anaemia who received adjuvant erythropoietin therapy with those who did not experience anaemia and received full-dose ribavirin,[2, 3] or compared patients who received adjuvant therapy from the beginning with patients who received placebo instead of erythropoietin.[4]

Erythropoietin is used exclusively for haematological support and it does not have an anti-viral effect or immune-regularity function and hence similarity of SVR in patients who received this agent compared with those who received placebo from the beginning of treatment is not surprising. However, similar SVRs in patients who received erythropoietin rather than ribavirin dose-reduction compared with those who did not develop anaemia, but received full-dose ribavirin is a success for erythropoietin – considering that these patients would be expected to have a significantly lower rate of SVR if they underwent ribavirin dose-reduction.[5]

To understand better the potential secondary effect of erythropoietin on SVR, we need to compare those who received this haematological support with those who received standard care – that is, ribavirin dose-reduction. Falasca *et al.*[6] and Sharvadze *et al.*[7] randomized patients who had developed anaemia to receive either erythropoietin or standard care; in these studies, those patients who received erythropoietin had a significantly higher probability of attaining SVR compared with those who received standard care, RR = 1.74 (95% CI 1.02–2.96) and 2.31 (95% CI 1.23–4.35) respectively.

ACKNOWLEDGEMENT

Declaration of personal and funding interests: None.

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doi:10.1111/j.1365-2036.2010.04372.x

Cytomegalovirus affects clinical outcome of infliximab in ulcerative colitis refractory to tacrolimus

Sirs, We read with great interest the original article by Herrlinger, *et al.* on infliximab (IFX) as rescue medication for patients with severe ulcerative/indeterminate colitis refractory to tacrolimus.[1] The authors concluded that IFX could be a therapeutic option for these patients refractory to tacrolimus, although the remission ratio was only 25%. We agree with the use of IFX as a rescue medication for patients with IBD refractory to tacrolimus. However, we are concerned about factors that would affect clinical outcome of IFX treatment.

We reported the efficacy and safety of IFX as a rescue therapy for patients with UC refractory to tacrolimus.[2] Six of 12 patients (50%) achieved clinical remission, but five patients required colectomy after IFX treatment. Of note, four (80%) of five colectomized patients were positive for cytomegalovirus (CMV) in colonic mucosa, while only one of seven non-colectomized patients was positive.[2] Recent studies have suggested that IFX could be a candidate for UC patients with CMV disease because of CMV reactivation triggered by TNF-α.[3–6] Both our and Herrlinger's case series demonstrated that IFX might be acceptable for IBD patients refractory to tacrolimus; however, prognosis of patients, with refractory UC in whom CMV reactivation in colonic mucosa was identified despite IFX administration, might be poor.

ACKNOWLEDGEMENT

Declaration of personal and funding interests: None.