Earlier need of infliximab intensification in Ulcerative Colitis than in Crohn’s disease

To the editors:

The response to infliximab (IFX) in Crohn’s disease (CD) and Ulcerative Colitis (UC) is initially good, although over time, a loss of response frequently occurs. Fifty percent of CD patients require IFX escalation,1 with regained responsiveness in majority of patients, at least in the short-term.2 Reports are scarcer regarding UC, however, early reports suggest a similar need for escalation in up to 60% of patients.3 Whether these patients have different long-term outcomes in clinical practice is unknown. We performed a retrospective observational study of IFX escalation and clinical outcome in CD and UC patients on scheduled treatment with IFX between 2004 and 2012 in order to evaluate loss of response and the requirement for IFX escalation. Patients losing response to IFX (recrudescence of symptoms and/or elevation of inflammatory markers) had

Figure 1  Hazard curves for infliximab escalation in inflammatory bowel disease patients stratified according to type of disease, with Crohn’s disease represented in the dotted line and Ulcerative Colitis in the continuous line.

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their treatment intensified by dose increase, by interval shortening or both. IFX intensification during the induction period occurred in patients who persisted symptomatic with inflammatory markers elevated (CD) and with deep ulceration (UC). All data were prospectively recalled in database (www.gediibasedados.med.up.pt). A total of 215 patients were analyzed, 163 (75.8%) with CD and 52 (24.2%) with UC. All patients had more than 18 years. Median follow-up time was 7 years (1–41). During follow-up, 34.4% (n = 74) of the patients had IFX escalation, with 33.7% (n = 55) of them being CD patients and 36.5% (n = 19) UC patients. In CD, 18.4% had dose increase and 31.9% had interval shortening. In UC patients this occurred in 15.4% and 34.6%, respectively. Fifty-five percent (n = 118) of the patients were on concomitant treatment with immunomodulators. UC patients had intensification earlier than CD patients (p = 0.041) (Fig. 1). No statistical significant differences were found in time to IFX intensification, neither in CD nor in UC, regarding gender, disease location, disease behavior, age at diagnosis, perianal disease, disease duration until beginning of IFX, combination therapy and previous treatment with immunomodulators. In conclusion, more than one third of IBD patients need IFX escalation during follow-up, with escalation occurring earlier in UC than in CD. The earlier need of IFX escalation in UC may be due to a more extensive disease burden in UC than in CD, to possible different pharmacokinetics aspects in tissue penetration of infliximab in the bowel wall in UC or to different detectable trough serum IFX levels in UC4 and in CD.5

Conflicts of interest

None declared.

References


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