

LETTER FROM THE EDITOR



While the advent of anti-tumor necrosis factor (anti-TNF) therapy has dramatically improved the treatment of inflammatory bowel disease (IBD), some clinicians remain concerned about the long-term adverse events that might be associated with these drugs. Specifically, infection and malignancy are serious risks that some clinicians have thought might be increased as a result of anti-TNF therapy.

To address these concerns, my coauthors and I performed a pooled safety data analysis of more than 2,000 patients in 10 trials, including 5 randomized controlled trials; patients in these trials received infliximab (Remicade, Janssen Biotech) or placebo with or without immunomodulators for the treatment of IBD. For our analysis, we determined pooled incidences and 95% confidence intervals for mortality, infection, and malignancy. The results of this analysis were recently published online ahead of print in *The American Journal of Gastroenterology* (2012 May 22. Epub ahead of print).

In this study, we found that immunomodulator therapy was associated with certain risks, although the type of risk differed for Crohn's disease (CD) versus ulcerative colitis (UC). CD patients who received immunomodulator monotherapy had a higher incidence of malignancy compared to patients who received placebo (1.84 per 100 patient-years vs 0.00 per 100 patient-years); however, this result was not found for patients with UC. Among patients with UC, those who received immunomodulators had a higher incidence of infections compared to patients who did not receive immunomodulators (120.07 per 100 patient-years vs 92.47 per 100 patient-years); again, this result was not found for patients with CD.

When we assessed the risks associated with the use of infliximab, however, we did not find any increase in the risk of infections, serious infections, or malignancy. In addition, mortality and infection-related mortality were not increased by either infliximab or immunomodulator treatment. Overall, these findings are quite encouraging and should reassure practicing clinicians about the safety of infliximab for the treatment of IBD.

Other encouraging data are presented in the review on therapeutic endoscopic ultrasound by Barham K. Abu Dayyeh and Michael J. Levy on page 450 of this month's issue of *Gastroenterology & Hepatology*. As this article discusses, advances in technology now allow endoscopic ultrasound to be used for a range of therapeutic applications, including drainage of fluid from the pancreas, the

gallbladder, or a pelvic abscess; balloon dilation and stent insertion in the pancreaticobiliary system; and celiac plexus block and neurolysis in patients with intractable abdominal pain due to pancreatic cancer or chronic pancreatitis. In addition, endoscopic ultrasound is being explored as a possible way to perform radiofrequency ablation, brachytherapy, and/or injection ablative therapies. All of these applications offer valuable alternatives to interventional radiologic and surgical methods, and clinicians will likely see more advances in this area as these procedures continue to evolve.

Finally, in a column on page 459, Mitchell Bernstein mentions a promising new treatment for fecal incontinence. As Bernstein discusses, injection of a biocompatible tissue bulking agent—called nasha dx (Solesta, Salix)—can reduce the number of fecal incontinence episodes and increase the number of fecal incontinence-free days. As there are currently limited options for patients with fecal incontinence who have failed conservative measures—aside from surgery, which carries risks and is contraindicated in certain patients—the availability of this new option offers hope for improved treatment of this challenging and burdensome condition.

In addition to Bernstein's column and the article by Abu Dayyeh and Levy, this issue of *Gastroenterology & Hepatology* also includes a review of the renal manifestations of hepatitis C virus infection as well as a case study describing 2 patients who presented following intentional foreign body ingestion. This month's other columns describe the management of patients who are not candidates for protease inhibitor therapy, cutaneous malignancies in patients with IBD, histologic features of gastroesophageal reflux disease and eosinophilic esophagitis, and extracorporeal shock wave lithotripsy with endoscopic retrograde cholangiopancreatography for treatment of chronic calcific pancreatitis.

Like the infliximab safety data discussed above, some of these articles may support or reinforce current clinical practice, while others may suggest new approaches or cautions. In both cases, I hope you find this material useful and valuable.

Sincerely,

A handwritten signature in black ink that reads "Gary R. Lichtenstein". The signature is fluid and cursive, with the first name being the most prominent.

Gary R. Lichtenstein, MD, AGAF, FACP, FACG