LETTER FROM THE EDITOR

Prior to the introduction of biologic medications, treatment of inflammatory bowel disease (IBD) often involved choosing among less-than-ideal options. For example, corticosteroids can effectively quell inflammation and reduce patients' symptoms, but these drugs are unsuitable for long-term use. On the other hand, medications such as aminosalicylates are safe for long-term use, but they often lack the efficacy needed to manage patients with severe disease.

Now that we have biologic medications, however, we can offer patients highly effective medications that are suitable for long-term use. Specifically, anti–tumor necrosis factor agents—such as adalimumab, certolizumab pegol, infliximab, and natalizumab—can induce and maintain remission even in patients with moderate-to-severe disease, and patients can be continued on these drugs longterm, if needed. For Crohn's disease (CD) or ulcerative colitis patients who have not achieved sufficient improvement with conventional therapies, these newer drugs represent a major breakthrough.

As with any drug, however, the benefit of these agents must be weighed against their side effects, which can include opportunistic infections and possibly an increased risk of cancer. One such risk, the potential for reactivation of chronic hepatitis B (CHB) infection following treatment with biologic agents, is highlighted in a clinical roundtable monograph that is included in this month's issue of *Gastroenterology & Hepatology*.

In this monograph, Nezam H. Afdhal, MD, Bruce R. Bacon, MD, and Robert S. Brown, Jr., MD, MPH, discuss several issues related to CHB, including long-term data on current treatments, how to categorize patients with CHB into clinically useful subgroups, and which treatment strategies are appropriate for various patient populations. One point of particular importance to gastroenterologists is the mention of how biologic medications can trigger CHB reactivation. According to Dr. Bacon, all patients who are positive for hepatitis B e antigen should be counseled about the risks of CHB reactivation before immunosuppressive therapy is initiated, and some of these patients may require prophylactic antiviral therapy, depending on the type of immunosuppressive therapy they are receiving. If prophylactic therapy is not initiated, then any patient who is at risk for CHB reactivation should be monitored carefully.

Of course, CHB reactivation is not the only possible side effect associated with biologic therapy. Reactivation of tuberculosis, other serious infections, and an increased risk of cancer are also potential concerns. Preventative measures, such as testing for latent tuberculosis infection, can help to minimize these risks in some patients. In other patients, however, the risk of side effects may be a contraindication to the use of a biologic medication, in which case alternative therapies may need to be employed instead.

As with any treatment, use of a biologic medication involves weighing the risks and benefits of a particular drug against the risks and benefits of alternative treatment options. If gastroenterologists decide that the use of biologic therapy would be beneficial for a particular IBD patient, then the risks associated with this therapy must be managed appropriately. In some cases, this may mean collaborating with our hepatology colleagues to prevent CHB reactivation.

In addition to this monograph on CHB, the current issue of *Gastroenterology & Hepatology* also includes a review of direct-acting antiviral medications being developed to treat hepatitis C virus (HCV) infection and a feature describing important steps to take when examining a new CD patient. This month's columns cover the possibility of interferon-free treatment for HCV infection, management and prevention of postoperative CD, use of propofol sedation by endoscopists, surgical options for treatment of reflux, and use of rifaximin for treatment of irritable bowel syndrome. Finally, our case this month describes a patient with *Strongyloides* infection and syndrome of inappropriate secretion of antidiuretic hormone.

Sincerely,

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