and the therapeutic management and progression of paradoxical skin lesions. All these data are essential to help physicians manage IBD patients receiving anti-TNF treatment.

A high rate of loss of response, severe side effects and the occurrence of paradoxical manifestations during anti-TNF treatment significantly limit their use and may strongly encourage physicians to consider the use of new biologics, such as vedolizumab or ustekinumab, as first-line therapy in IBD patients. The results of head-to-head studies comparing anti-TNF treatments to new biologics in naive IBD patients are urgently awaited.

ACKNOWLEDGEMENT

Declaration of personal interests: Benjamin Pariente has served as a speaker, a consultant and advisory board to Abbvie, Ferring, MSD, Takeda, Hospira, Janssen, Pfizer, Biogaran, and has received research funding from Abbvie and Janssen.

FUNDING INFORMATION

None.

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LINKED CONTENT

This article is linked to Bae et al and Lee et al papers. To view these articles visit https://doi.org/10.1111/apt.14822 and https://doi.org/10.1111/apt.14917.

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DOI: 10.1111/apt.14917

Editorial: paradoxical skin lesions during anti-TNF treatment—an additional argument to consider new biologics as first-line therapy in inflammatory bowel disease. Authors’ reply

We appreciate Drs. Pariente and Blondeaux for their thoughtful comments regarding our study.1,2

This study was inspired by patients we treated. The occurrence of inflammatory bowel disease (IBD) is increasing rapidly in Korea and elsewhere in Asia as these societies have become more westernised.3

In response to this increase, infliximab has been prescribed since 2005 after approval for coverage by the National Health Insurance Service. Adalimumab was also approved for coverage by the National Health Insurance Service in 2006. Thus, claims data for anti-TNF agents prescribed to IBD patients can be analysed for more than a 10-year period.
As we point out in our work, Korea National Health Insurance is a mandatory nationwide insurance system operated by the Korean government. Prescription and diagnosis data for almost all Koreans are recorded in this database. Therefore, this database is suitable for conducting studies on relatively rare conditions such as IBD and psoriasiform diseases.

The authors of the Editorial remark that our work demonstrated significant risk of paradoxical psoriasiform diseases secondary to anti-TNF treatment compared with age- and sex-matched controls not receiving anti-TNF agents using a nationwide population-based cohort for the first time. However, they pointed out some limitations including the absence of details on the characteristics of IBD, previous treatment before anti-TNF agents and the therapeutic management and progression of paradoxical skin lesions, which are clear drawbacks. We expect that the detailed evolution of paradoxical skin reactions will be investigated using a hospital-based cohort in the near future.

We generally agree with the statements made regarding the use of vedolizumab or ustekinumab as the first-line biologic agents in the treatment of IBD. However, before use of vedolizumab, we should still take account of the relatively slow onset, rates of associated infections (5%-24%) and severe adverse events (0%-13%) from real-world studies as well as paradoxical skin manifestations including exanthematous pustulosis and palmar erythema. Although ustekinumab was believed to have positive long-term efficacy and a good safety profile, it has been approved for use only in the treatment of Crohn’s disease, not ulcerative colitis.

While our study clearly demonstrated that the use of anti-TNF agents in IBD patients is associated with an increased risk of paradoxical psoriasiform diseases, the absolute incidence of psoriasis, palmar plantar pustulosis and psoriatic arthritis remained low (36.8, 5.9 and 14.8 per 10 000 person-years, respectively). We believe that anti-TNF agents can hold their position until the role of these two newer biologics as the first-line treatments in biologic-naive IBD patients can be further evaluated.

ACKNOWLEDGEMENTS

The authors’ declarations of personal and financial interests are unchanged from those in the original article.

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LINKED CONTENT

This article is linked to Bae et al and Pariente and Blondeaux papers. To view these articles visit https://doi.org/10.1111/apt.14822 and https://doi.org/10.1111/apt.14903.

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