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*Letter to the Editor*

# Infliximab for hidradenitis suppurativa in Crohn's disease

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Sir, it is with great interest that we read the paper of Sullivan et al.[1] (Br J Dermatol 2003; 149:1046-1049) about Infliximab use in hidradenitis suppurativa (HS). We would like to briefly comment on a few issues addressed in this paper related to Infliximab treatment in patients with HS and Crohn's disease, as we have already reported a similar case of successful treatment[2]. In fact, for nearly four years now we have been successfully treating with Infliximab (8-weekly infusions, 5mg/kg) a 40-year-old man with axillary HS related to his fistulizing severe Crohn's disease. In the paper of Sullivan et al. the longest period between an HS treatment episode and the interview was only six months and the number of infusions was extremely low (one or two infusions per patient). We believe that the short follow up period and the non-administration of regular maintenance infusions are the main reasons why the great majority of HS patients did not experience marked improvement or even relapsed. In fact, it seems that regardless of Crohn's or other systemic disease co-existence, Infliximab administration in such HS patients should be reasonably prolonged, probably lasting for several months in some difficult cases, in order to obtain and maintain the initial optimal results. In addition, HS cases with poor initial response to Infliximab infusions will probably do better as the cumulative number of doses increases over time. To our knowledge, no experience with regard to dosage increase (over 5mg/kg) in HS Infliximab-resistant patients so far exists. In addition, the optimal number of Infliximab doses in maintaining long-term remission in fistulizing Crohn's disease still remains under debate. The dosage of concurrent medications was reported to be stable or even decreased during Infliximab therapy in these case series of Sullivan et al. We feel that drug dosage reduction or even drug discontinuation in severe cases of HS must be decided after achieving the optimal long-term result with Infliximab infusions. The accumulating experience with Infliximab use in fistulizing Crohn's disease patients with or without extraintestinal manifestations, including HS,[3,4] underlines the importance of concurrent treatment acting as a pyramid in which Infliximab represents the top. In addition, physicians should be insisting on this therapy, as, in our experience it seems that enterocutaneous fistula closure precedes the healing of HS lesions. Tapering of concurrent medications, when decided, must be done under a close patient follow-up and after several Infliximab doses, in order to prevent disease relapse or even complete failure of treatment and patient disappointment. In fact, in our patient with Crohn's disease and HS, we achieved significant reduction of medical treatment during these four years; corticosteroid tapering (methylprednizolone from 16mg/day to 4mg every second day) and HS local therapy discontinuation while azathioprine was maintained at the pre-Infliximab dosage levels (150mg/day).

The last issue to address is the long-term risks of Infliximab infusions, including tuberculosis and malignancy. We completely agree with Sullivan et al that close clinical monitoring and a high index of suspicion for tuberculosis are required when treating patients with Infliximab. In addition, the co-administration of Infliximab in patients already systemically receiving other immunosuppressive drugs must also go along this clinical rule. Although few patients have been treated with Infliximab for extended periods of time, malignancy risk represents a controversial topic. In a recent study[5] it has been suggested that the preclinical data and the early clinical expe-

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rience presented for anti-TNFα (Infliximab) do not provide evidence for a causal relationship between TNFα antagonism and the development of lymphoid or non-lymphoid cancers. Moreover, no evidence exists on the impact of Infliximab on benign or hyperplastic conitions.

From our point of view,[6] unless the absolute risk of inflammatory bowel disease patients developing malignancies is assessed extensively, no secure statements about the hyperplastic or carcinogenesis effect of any kind of therapy, especially of the new biological agents including Infliximab, should be generalized or adopted in any current guidelines.

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